EFFECTIVE CHIROPRACTIC
Health and Wellness Center

PEDIATRIC HISTORY FORM

Dear Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please complete the following information. We look forward to working with you to build better health for your family.

Patient Information

Name: _____ S.S. #: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Ph: _____
Birth Date: _____ Sex: M F Weight: _____ Height: _____
Referred By: _____

Parent/Guardian Information

Name(s): _____
Cell Ph: _____ Work Ph: _____
Birth Date: _____ S.S. #: _____

Purpose for Contacting Us? _____
Have you seen others doctors for this condition?:_____ N _____ Y

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from during the Past Six Month:

_____ Ear Infections	_____ Scoliosis	_____ Seizures	_____ Colds
_____ Headaches	_____ Asthma/Allergies	_____ Digestive Problems	_____ ADHD
_____ Recurring Fevers	_____ Growing/Back Pain	_____ Colic	_____ Bed Wetting
_____ Car Accident	_____ Temper Tantrums	_____ Other: _____	

Family History/Health Problems? _____
_____

Previous Chiropractor: _____ Date of Last Visit: _____

Number of Doses of *Antibiotics* Your Child has Taken:
During the Past 6 Months: _____, During Last Year: _____

Number of Doses of *Other Prescription Medications* Your Child has Taken:
During the Past 6 Months: _____, During Last Year: _____

Number of Doses of *Over-the-Counter Medications* Your Child has Taken:
During the Past 6 Months: _____, During Last Year: _____

Prenatal History

Complications During Pregnancy? _____ N _____ Y, List: _____
Medications During Pregnancy/Delivery? _____ N _____ Y, List: _____
Location of Birth: _____ Hospital _____ Birthing Center _____ Home
Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section

Complications During Delivery? _____ N _____ Y, List: _____
Genetic Disorders or Disabilities? _____ N _____ Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History

Breast Fed? _____ N _____ Y, How Long: _____
Formula Fed? _____ N _____ Y

Developmental History

Please list any falls your child has had in the past (i.e. from changing tables, stairs, bed, bike, tub, etc.).

1. _____
2. _____
3. _____

Is/has your child been involved in any impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ N _____ Y, List: _____

Has Your Child Ever Been Involved in a Car Accident Over 3mph? _____N _____Y, When: _____
List Details: _____

Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y, List: _____

Other Traumas Not Described Above? _____N _____Y, List: _____

Prior Surgery? _____N _____Y, List: _____

Childhood Diseases

Chicken Pox	N	Y, Age _____	Mumps	N	Y, Age _____
Rubella	N	Y, Age _____	Whooping Cough	N	Y, Age _____
Rubeola	N	Y, Age _____	Other	N	Y, Age _____

Please list all others: _____

Other Information

What percentage (%) of the day does your child...
_____ play outside or exercise?
_____ play videos games/watch TV/play on computer?
_____ engage in activities? (church, sports, school, etc.) Please List: _____

Rate your child's food intake: 1 2 3 4 5 6 7 8 9 10
(Poor – Processed Foods/TakeOut/Fast Food) to (Organic, Fresh, Healthy)

Rate your child's school performance: 1 2 3 4 5 6 7 8 9 10
(Poor) (Average) (Outstanding)
What could improve? _____

How many days per year does your child miss school due to illness? 0 1-2 3-6 7 or more

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office at time that services are rendered.

Name of Insurance Company: _____ Policy #: _____

Print Name: _____ Signature: _____ Date: _____