



Pediatric History Form

Date: _____

Name: _____ DOB: _____

Mother's Name _____ Father's Name _____

Mother's Address _____ City _____

State _____ Zip _____ Telephone # _____ Cell _____

Father's Address (if different) _____ City _____

State _____ Zip _____ Telephone # _____ Cell _____

Referred by _____

Present MD and Address _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature Date

Witness Signature Date

CHIEF HEALTH CONCERNS

List other care undergone for this/these complaint(s), including medications:



Date of Onset _____ Onset was (check one): Sudden ____ Gradual _____

Duration of problem (episode) _____ minutes hours days months years

Pattern of problem: Constant intermittent Occasional Cyclical

Any prior occurrences or episodes? _____

Prior treatment and results: _____

Present Length/Height _____ Weight _____

HISTORY OF BIRTH

Hospital/Birthing Center: Home Medical Midwife

Duration of Gestation: _____ Weeks

Assisted With: Forceps, Vacuum Extraction C-Section, Induced Labor Duration of labor: _____ Duration of birth: _____

Complications at birth: _____

Medications delivered to mother at birth? _____

Was delivery normal? Yes No

APGAR at Birth _____ After 5 Minutes _____

Birth Weight _____ Birth Length _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? Yes No

Explain _____

Has child reached all milestones on time? If no, which were delayed?

Do sleeping patterns seem normal to you? Yes No

Family Health Problems:

Mother's side _____

Father's side _____

Siblings _____



CHEMICAL/FEEDING HISTORY

Was baby breast-fed? No Yes

How Long? _____ Formula introduced at age _____

Type of formula used: _____ Cow's milk introduces at age _____

Began solid foods at age _____ Food/Juice intolerance No Yes Type: _____

During pregnancy did mother:

Smoke? Yes No Drink alcohol? Yes No

Any illness of the mother during pregnancy? _____

Supplements taken during pregnancy? _____

Any drugs taken during pregnancy? _____

Any exposure to ultrasound? No Yes

If so, how many, why? _____

Any invasive procedures (Amniocentesis, CVS) _____

Any pets at home? No Yes

Any smokers in the home? No Yes How much? _____

Any vaccinations? No Yes

Which ones, and any reactions? _____

Any antibiotics? No Yes For: _____

Total number of courses of antibiotics to date: _____

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? No Yes

Any problems with bonding? Mother Father

Any behavioral problems? No Yes

Type: _____ Onset: _____

Any night terrors, sleepwalking, difficult sleeping? No Yes

Specify _____

Age when daycare began? _____



Average number of hours of television per week? _____

Does your child seem normal for their age? Yes No

TRAUMATIC STRESSORS

Any traumas during pregnancy (falls, accidents)? _____

Any evidence of birth trauma: bruises, odd-shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other? _____

Any falls from couches, beds, change tables? _____

Any traumas with bruising, cuts, stitches, fractures? _____

Any hospitalizations? No Yes

Explain: _____

Any surgeries or organs removed? _____

Sports played and age began: _____

Weight of school backpack: _____ Approx. hours spent at play per week: _____

Thank you for completing this form. Please write any other questions/concerns you have below.
