Cole
Chiropractic & Wellness

PEDIATRIC HISTORY FORM

Child's Name _____
Address _____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ Email _____
Birth Date _____ Sex ___ Weight _____ Height _____ Number of siblings _____
Who referred you? _____
Reason for seeking chiropractic care? _____

Is this condition ☐ getting worse ☐ constant ☐ comes and goes
Is this condition interfering with ☐ sleep ☐ daily routine ☐ meals

Has the child had similar conditions in the past? ☐ yes ☐ no When? _____
Other doctors seen for this condition? ☐ yes ☐ no When? _____
Prior treatment and outcome: _____ _____
Other health problems: _____

SYMPTOMS
(Please check any current or past problems your child has on this list below.)

☐ Dizziness
☐ ADHD
☐ Backaches
☐ Heart Condition
☐ Chronic Earaches
☐ Diabetes ☐ Tuberculosis
☐ Hypertension
☐ Fever/Chills
☐ Frequent Colds
☐ Arthritis
☐ Headaches
☐ Asthma
☐ Allergies
☐ Runny Nose
☐ Itchy Eyes
☐ Rashes
☐ Unusual Moles
☐ Neuritis
☐ Digestive
☐ Sinus Trouble
☐ Cough/Wheeze
☐ Chest Pain
☐ Constipation
☐ Anemia
☐ Rheumatic Fever
☐ Diarrhea
☐ Poor Appetite
☐ Hyperactivity
☐ Behavioral
☐ Poor Memory
☐ Insomnia
☐ Nightmares
☐ Bedwetting
☐ Pain Urinating
☐ Convulsions ☐ Paralysis
☐ Muscle Pain
☐ Fainting
☐ Broken Bones
☐ Sprains/Strains
☐ Hernias
☐ Neck Pain
☐ Arm/Elbow Pain
☐ Leg/Hip Pain
☐ Growing Pains
☐ Joint Pain
☐ Scoliosis
☐ Blood Disorders
☐ Stomachaches
☐ Other

HEALTH HISTORY

Name of Pediatrician: _____

Medications: _____

Conditions being treated: _____

Has your child ever taken antibiotics? □ yes □ no Condition treated: _____

Has your child been injured participating in contact sports (soccer, football, martial arts, etc.) ? □ yes □ no

If yes, describe (sprain, broken bone, head trauma, etc.) _____

Has your child ever been involved in a car accident? □ yes □ no Date & Injuries: _____

Has your child ever fallen head first (from changing table, bed, stairs, etc.)? □ yes □ no

Other traumas not described above? □ yes □ no Type & Date: _____

Prior surgery? □ yes □ no Type & Date: _____

PRENATAL HISTORY

Location of Birth ☐ home ☐ birthing center ☐ hospital ☐ stepchild ☐ adopted

Complications during pregnancy? □ yes □ no List _____

Ultrasound during pregnancy? □ yes □ no

Medications during pregnancy? □ yes □ no

Birth intervention: □ forceps □ vacuum □ Cesarean Why? _____

Complications during delivery? □ yes □ no List _____

Genetic disorders or disabilities? □ yes □ no List _____

Birth weight _____ Birth Length _____ Apgar Scores: 1 min _____ 5 min _____

FEEDING HISTORY

Breastfed? □ yes □ no How Long? _____ Formula fed? □ yes □ no How Long? _____

Type? Introduced to solids at ___ mo Cow's milk at ___ mo

Food/juice allergies or intolerances? □ yes □ no ___ List _____

How would you rate your child's diet? □ well balanced □ average □ high sugar/processed food

DEVELOPMENTAL HISTORY

Sleep (hours/night) _____ Naps (number & lengths) _____ Problems sleeping? □ yes □ no

At what age was your child able to crawl ? _____ sit alone ___ walk alone _____ Say words _____

CHILDHOOD DISEASES

☐ Chicken pox – Age ___ ☐ Mumps – Age ___ ☐ Rubella - Age ___ ☐ Whooping cough – Age ___

☐ Measles – Age ___ ☐ Meningitis – Age ___ ☐ Tuberculosis – Age ___ ☐ Other – Age ___

VACCINATION HISTORY

☐ HBV / Hep B (Hepatitis B) – Age ___ ☐ MMR (Measles, Mumps, Rubella) – Age ___

☐ DTP or ☐ DTaP (Diphtheria, Tetanus, Pertussis) – Age ___ ☐ Varicella (Chicken Pox) – Age ___

☐ HbCV / Hib (H. influenzae type b conjugate) – Age ___ ☐ PVC (Pneumococcal) – Age ___

☐ OPV (Oral Polio Vaccine) – Age ___ ☐ IPV (Inactivated Poliovirus) – Age ___

Adverse reactions to any vaccine? ☐ yes ☐ no List: _____

OTHER INFORMATION YOU WANT TO SHARE _____

INSURANCE

Do you have medical insurance □ yes □ no

Insurance Company Name _____

Policy Number _____ Group Number _____

Insurance Company Phone Number _____

Insured's Name _____ Relationship to patient _____

Insured's Address (if different from child) _____

Insured's DOB _____

Insured's Employer _____ Insured's Employee Address _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge. I, _____, hereby the parent/legal guardian of _____ grant permission for my child to receive chiropractic care.

Communications

In the event that we would need to communicate your healthcare information to whom may we do so?

Spouse: _____

Children: _____

Others: _____

□ No one

Acknowledgement

I have read and fully understand the above statements. I have reviewed the Notice of Privacy Practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Print Name: _____

Signature: _____ Date: _____