

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? _____ Specialty? _____

Prior treatment and outcome: _____

Other health problems: _____

Has the child ever received chiropractic treatment? yes no When? _____

SYMPTOMS

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

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

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 When? _____
Other traumas not described above? yes no Type & Date: _____
Prior surgery? yes no Type & Date: _____
Menarche: yes no Age: _____

PRENATAL HISTORY

Location of Birth home birthing center hospital stepchild adopted
Complications during pregnancy? yes no List _____
Ultrasound during pregnancy? yes no How Many? _____
Cigarette/ Alcohol use during pregnancy? yes no _____
Medications during pregnancy/delivery? yes no List _____
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 _____
Cigarette/alcohol use during pregnancy yes no

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? _____ Stand 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

May we leave messages regarding personal healthcare information on any answering device, i.e., home answering machine or voice mails? yes no

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: _____