

Pediatric Health History Form

(For Children 6 Years and Under)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Called Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Home Ph: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_Male \_\_\_\_\_ Female

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose for contacting Atlantic Chiropractic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have other Doctors been seen for this condition? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, Please list Doctor Name(s) and Prior Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other health problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the following conditions your child has experienced or been diagnosed with during the past six months:

□ Ear Infections □Digestive Problems □ Car Accident □ Headaches

□ Asthma/Allergies □ Bed Wetting □ Chronic Colds □ Growing Pains (Back, Legs, Arms, etc.)

□ Colic □ Seizures □ Recurring Fevers □ Autism

□ Scoliosis □ ADD/ADHD □ Temper Tantrums □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any significant Family Health History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of antibiotics your child has taken during the past 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_ During their lifetime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of doses of other Prescription Medications your child has taken during the past 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During his/her lifetime: \_\_\_\_\_\_\_\_\_\_\_ Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccination History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Obstetrician/Midwife: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications during Pregnancy: □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasound during Pregnancy: □ Yes □ No #: \_\_\_\_\_ Genetic Disorders or Disabilities: □ Yes □ No List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications during Pregnancy/Delivery: □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette/Alcohol use during pregnancy: □ Yes □ No Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section If C-Section, □ Planned □ Emergency

Complications during delivery: □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Length: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APGAR Scores: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEEDING HISTORY IF CHILD IS 2 YEARS OF AGE OR UNDER**

Breast Fed: □ Yes □ No How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_ Formula: □ Yes □ No How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Introduced to Solids at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Months Introduced to Cow’s Milk at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Months

Does your child have **ANY** Food/Juice Allergies or Sensitivities: □ Yes □ No If Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I s your child currently taking ANY medication, prescription or over-the-counter? [] Yes [] No

If Yes. Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEVELOPMENTAL HISTORY

During the following developmental stages your child’s spine is most vulnerable to stresses and should routinely be checked by a Chiropractor for prevention and early detection of vertebral subluxation (Spinal Nerve Interference). At what age was your child able to:

Respond to Sound: \_\_\_\_\_\_\_\_\_\_ Respond to Visual Stimuli: \_\_\_\_\_\_\_\_\_\_ Hold Head Up: \_\_\_\_\_\_\_\_\_\_\_

Sit Up: \_\_\_\_\_\_\_\_\_\_\_ Cross Crawl: \_\_\_\_\_\_\_\_\_\_\_ Stand Alone: \_\_\_\_\_\_\_\_\_\_\_\_ Walk Alone: \_\_\_\_\_\_\_\_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: A bed, changing table, stairs etc.). Has your child had a head-first fall? □ Yes □ No

Is/Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, martial arts, cheerleading etc.):

□ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child **EVER** been involved in a car accident? □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been seen on an emergency basis? □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other traumas not described above? □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY** Prior Surgery? □ Yes □ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have difficulty interacting with others? □ Yes □ No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? □ Yes □ No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What changes (if any) in your child’s health or behavior would you like accomplished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDHOOD DISEASES: (Please mark all that apply.)

□ Chicken Pox Age: \_\_\_\_\_\_\_\_\_\_ □ Mumps Age: \_\_\_\_\_\_\_\_\_

□ Rubella Age: \_\_\_\_\_\_\_\_\_\_ □ Whooping Cough: Age: \_\_\_\_\_\_\_\_\_

□ Rubeola Age: \_\_\_\_\_\_\_\_\_\_ □ Other(s) List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WE ARE HERE TO SERVE YOU AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD’S RESULTS.**

INFORMED CONSTENT AUTHORIZATION FOR TREATMENT AND CARE OF A MINOR

I hereby authorize Atlantic Chiropractic and Wellness Center, its Doctors and staff to administer Chiropractic care to my son/daughter as they deem necessary. I am clearly aware of the benefits of care, as well as mild potential for risks involved with care, including sprain/strains, tenderness or pain, and in some very rare cases, fracture. I also clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_