

PEDIATRIC PATIENT HISTORY

CHILD'S NAME: _____ DATE: _____

D.O.B.: _____ GRADE IN SCHOOL: _____ SEX: _____ HOME PHONE: (____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ PARENT E-MAIL ADDRESS: _____

MOTHER'S NAME: _____ CELL/WORK PHONE: _____

FATHER'S NAME: _____ CELL/WORK PHONE: _____

INSURANCE CO: _____ POLICY HOLDER: _____ POLICY #: _____

PURPOSE OF THIS APPOINTMENT: _____

PEDIATRICIAN: _____ TEL: (____) _____

Pregnancy History

(If the child is adopted, answer to the best of your ability.)

Did you experience any of the following during your pregnancy:

- Severe viral infection during the first trimester
- Breech position during pregnancy
- Accident or Infections
- Smoking
- Severe stress
- Pre-eclampsia
- Alcohol consumption and/or drug use
- Radiation exposure
- Hypertension (high blood pressure)
- Toxoplasmosis
- Uncontrolled Diabetes
- Toxemia

Labor and Delivery History

Did you and/or the child experience any of the following during labor/delivery:

- Hospital Birth
- Birthing Home
- Long and/or difficult labor
- Placenta Previa
- Forceps or suction cups used
- Fetal Distress
- Elective C-section
- The child was a "blue baby"
- Home Birth
- Labor was induced
- The delivery was rapid
- Breech Birth
- Cord around the neck
- Emergency C-section
- Premature delivery (2+ weeks)

Comments: _____

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Newborn History

Did the child experience any of the following as a newborn:

- | | |
|---|---|
| <input type="radio"/> Required resuscitation/oxygen | <input type="radio"/> Distorted skull |
| <input type="radio"/> Prolonged jaundice | <input type="radio"/> Difficulty latching/sucking |
| <input type="radio"/> Poor sleeper | <input type="radio"/> Formula fed |
| <input type="radio"/> Immunizations in hospital | <input type="radio"/> Breast fed |
- If yes, please specify vaccine: _____ Bottle fed
 Colic

Weight at birth: _____

Length at birth: _____

Health History

Has your child ever experienced the following, or been diagnosed as having any of the following:

- | | |
|---|---|
| <input type="radio"/> Illnesses accompanied by a high fever | <input type="radio"/> Dizziness |
| <input type="radio"/> Frequent Headaches | <input type="radio"/> Diabetes |
| <input type="radio"/> Seizures/Convulsions | <input type="radio"/> Hypoglycemia (low blood sugar) |
| <input type="radio"/> Chronic ear infections/earaches | <input type="radio"/> Trouble with bladder control (enuresis) |
| <input type="radio"/> Head Injury | <input type="radio"/> Fainting |
| <input type="radio"/> Serious fall(s) or repetitive falls | <input type="radio"/> High blood pressure |
| <input type="radio"/> Epilepsy | <input type="radio"/> Heart Disease |
| <input type="radio"/> Meningitis | <input type="radio"/> Asthma |
| <input type="radio"/> Allergies to foods | <input type="radio"/> Sinus problems |
| <input type="radio"/> Environmental Allergies | <input type="radio"/> Constipation |
| <input type="radio"/> Chemical Insensitivities | <input type="radio"/> Diarrhea |
| <input type="radio"/> Undergone surgery | <input type="radio"/> Digestive disorders |
| <input type="radio"/> Neck or back problems | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Adverse reaction to any vaccinations (even if mild) | <input type="radio"/> Joint or muscle problems |

If yes, please explain: _____

Developmental History

Does or did your child have any of the following:

- | | |
|---|--|
| <input type="radio"/> Difficulty with crawling (on all fours) | <input type="radio"/> Did not crawl on all fours |
| <input type="radio"/> Difficulty learning to ride a bike | <input type="radio"/> Appears clumsy |
| <input type="radio"/> Difficulty learning to read | <input type="radio"/> Difficulty with writing |
| <input type="radio"/> Difficulty using utensils | <input type="radio"/> Difficulty buttoning clothes |
| <input type="radio"/> Difficulty tying shoes | <input type="radio"/> Difficulty or awkward with walking/running |
| <input type="radio"/> Poor hand-eye coordination | <input type="radio"/> Difficulty sitting still or paying attention |

At what age did your child start to walk unassisted: _____

Comments: _____

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Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- Hearing loss or impairment
- Neurological disorders
- Obsessive Compulsive Disorder (OCD)
- ADD/ADHD
- Dyslexia
- Visual Impairment
- Anxiety/Depression requiring treatment
- Autism/Autism Spectrum Disorder
- Tourette's Syndrome
- Other _____

Current/Past Medications and Treatment

List any medications that your child is taking:

List names, dosage, frequency

List any special dietary needs that your child has:

List any supplements your child takes:

List any treatment that your child is currently undergoing with any health professional:

List any special services that your child is currently receiving at school or privately:

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:

Comments: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize _____, D.C. to evaluate and treat my son/daughter as he/she deems necessary.

I acknowledge that I am financially responsible for any and all fees charged by Greater Rochester *family & sports* Chiropractic and that payment will be made as services are provided.

Signature and relation of person completing this form

Date

Signature of Witness

Date