WEST MICHIGAN CHIROPRACTIC

Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brains, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____S.S.#: _____Birth Date: __/__/__

Male/ Female (Circle one) Weight: ____lbs. Height___ft.___in. Phone #_____

Address:_____City:_____

State:_____ Zip:_____ Parent/ Guardian:_____

Referred by:_____

Reason for pursuing care: ☐ maintenance ☐ improved health ☐ problem: _____

Other doctors seen for this condition? Y/ N

Doctor's names and prior treatment:

_____

_____

List any other health problems: _____

Family history: _____

Check any of the following conditions that currently apply:

__ Ear infections __ Scoliosis __ Chronic colds __ Headaches

__ Allergies __Digestive problems __ADHD/ADD __ Recurring Fevers

__ Colic __Growing/ back pains __Bed wetting __Temper tantrums __

Seizures __Asthma __Car accident: When? _____

Other: _____

Previous Chiropractic Care? Y/ N Last visit: __/__/__

Name of Pediatrician: _____ Last visit: __/__/__

Are you satisfied with the care your child has received at the pediatrician? Y/N

# of Doses of antibiotics your child has taken: Past 6 months_____ Total lifetime _____

Present prescription drugs/ dosage? _____

Past prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Pediatric History Form Continued

Child's Name _____ Date: _____

Prenatal History- (Circle what applies)

Name of Obstetrician/ Midwife: _____

Complications during pregnancy/ delivery? Y/N Explain: _____

Ultrasounds during pregnancy? Y/N How many?_____

Medications taken during pregnancy/ delivery? Y/N List:_____

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: ____Emergency or ____ Planned (check one)

Genetic disorders/ disabilities? Y/N List: _____

Birth Weight: _____ Birth Length: _____APGAR Scores: _____-_____

Feeding History

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type:_____

Introduced to: Solid Foods @_____ months Cow's milk @ _____ months

Food/ Juice allergies or intolerances: Y/ N List: _____

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

_____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? Y/N
Explain:_____

Has your child been involved in any sports? Y/N List: _____
_____

Has your child been seen by a physician on an emergency basis? Y/N Explain: _____

_____

Other traumas not described above? _____

Lifestyle- please check what applies

Does your child: ☐ eat health food products (organic products, etc.) ☐ drink water

☐ take vitamins Type: _____ ☐ take probiotics

Exercise: ☐ none ☐ moderate ☐ daily ☐ heavy

Hobbies/ interests: _____

_____

Is there anything else you would like us to know about your child? _____

_____

Parent/ Guardian name: _____Signature: _____