

# PEDIATRIC HISTORY FORM

Name: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: (D/M/Y) \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Names of parents/guardians: \_\_\_\_\_ Referred by: \_\_\_\_\_

## ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your child's health expression. This case history will uncover the layers of damage, especially to your child's nerve system, that have resulted in poor health. Following the exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your child's innate health potential.

## PURPOSE FOR CONTACTING US

Spinal check-up: \_\_\_\_\_ other: \_\_\_\_\_ other doctors seen for this condition:  YES  NO

Doctors names and prior treatments: \_\_\_\_\_

Other health problems: \_\_\_\_\_

Pertinent family history: \_\_\_\_\_

Has this child been under previous Chiropractic care:  YES  NO Date of last visit: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Number of doses of antibiotics your child has taken: \_\_\_\_\_ # of doses taken during the past 6 months: \_\_\_\_\_

Total # of doses taken during his/her lifetime: \_\_\_\_\_

Number of doses of other prescription medications your child has taken: \_\_\_\_\_ # of doses taken during the past 6 months: \_\_\_\_\_

Total # of doses taken during his/her lifetime: \_\_\_\_\_

Have you chosen to vaccinate this child:  YES  NO

Reactions following vaccination (up to 30 days post vaccine): \_\_\_\_\_

## PRENATAL HISTORY

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy:  YES  NO List: \_\_\_\_\_

Ultrasounds during pregnancy:  YES  NO Number: \_\_\_\_\_

Complications during delivery:  YES  NO List: \_\_\_\_\_

Medications during pregnancy/delivery:  YES  NO List: \_\_\_\_\_

Location of birth: Hospital  Birthing Centre  Home  Other: \_\_\_\_\_

Birth intervention: Forceps  Vacuum extraction  Cesarean section  other  \_\_\_\_\_

APGAR Score(s) \_\_\_\_\_ Cigarette/alcohol use during pregnancy:  YES  NO \_\_\_\_\_

Genetic disorders or disabilities:  YES  NO List: \_\_\_\_\_

## FEEDING HISTORY

Breast fed:  YES  NO How long: \_\_\_\_\_

Introduced: Solids at \_\_\_\_\_ months Introduced: Cow's milk at \_\_\_\_\_ months

Food/juice allergies or intolerances:  YES  NO List: \_\_\_\_\_

## DEVELOPMENTAL HISTORY

According to the National Safety Council, approximately 50% of children fall from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child?  YES  NO

Is or has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)?  YES  NO

Has your child ever been involved in a car accident?  YES  NO List: \_\_\_\_\_

Has your child ever been seen on an emergency basis?  YES  NO List: \_\_\_\_\_

Other traumas not described above:  YES  NO List: \_\_\_\_\_

Hospitalization or priority surgery:  YES  NO List: \_\_\_\_\_

## CHILDHOOD DISEASES

Chicken pox  YES  NO Age \_\_\_\_\_

Mumps  YES  NO Age \_\_\_\_\_

Rubella  YES  NO Age \_\_\_\_\_

Whooping Cough  YES  NO Age \_\_\_\_\_

Rubeola  YES  NO Age \_\_\_\_\_

Other  YES  NO Age \_\_\_\_\_

Does your child or his/her siblings suffer from:

Asthma  YES  NO Age \_\_\_\_\_

Skin problems  YES  NO Age \_\_\_\_\_

Allergies  YES  NO Age \_\_\_\_\_

Difficulty sleeping  YES  NO Age \_\_\_\_\_

Hyperactivity  YES  NO Age \_\_\_\_\_

Colic  YES  NO Age \_\_\_\_\_

Bed wetting  YES  NO Age \_\_\_\_\_

Constipation  YES  NO Age \_\_\_\_\_

Ear infections  YES  NO Age \_\_\_\_\_

Diarrhea  YES  NO Age \_\_\_\_\_

## AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

### INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE.

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

Signature \_\_\_\_\_ Date signed \_\_\_\_\_