SeaCoast
FAMILY CHIROPRACTIC

Pediatric History Form

Name: _____ Date: _____/_____/_____

Name of Parents/Guardians: _____

Address: _____City: _____State: ____Zip: _____

H. Phone: (_____)_____ W. Phone: (_____)_____

C. Phone: (_____)_____ Email Address: _____

DOB: _____/_____/_____ Age: _____ Sex: _____ Height: _____ Weight: _____

Number of Siblings: _____ SS #: _____Who referred you to us? _____

How were you referred to our office? _____

_____

Reason for seeking Chiropractic Care: _____

Chief Complaint: _____

Other Doctors seen for this condition Y / N (Specialty): _____

Prior treatment outcome: _____

Other health problems: _____

Symptoms: *Please check any current or past problems your child has on the list below:*

__Dizziness	__Allergies	__Diarrhea	__Broken Bones
__ADHD/ADD	__Runny nose	__Poor Appetite	__Sprains/Strains
__Backaches	__Itchy Eyes	__Hyperactivity	__Hernias
__Heart Condition	__Rashes	__Behavioral	__Neck Pain
__Chronic Earaches	__Unusual Moles	__Poor Memory	__Arm/Elbow Pain
__Diabetes	__Neuritis	__Insomnia	__Leg/Hip Pain
__Tuberculosis	__Digestive	__Nightmares	__Knee/Foot Pain
__Hypertension	__Sinus Trouble	__Bed Wetting	__Growing Pains
__Fever/Chills	__Cough/Wheeze	__Pain Urinating	__Joint Pain
__Frequent Colds	__Chest Pain	__Scoliosis	__Convulsions/Paralysis
__Arthritis	__Constipation	__Muscle Pain	__Blood Disorders
__Headaches	__Anemia	__Fainting	__Stomach Aches
__Asthma	__Rheumatic Fever	__Other: _____	

Explain checked conditions: _____

_____

_____

Please answer all questions to the best of your ability. Thank you:

Health History:

Name of Pediatrician: _____ Date of last visit: _____/_____/_____

Reason for visit: _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? Y / N Condition treated: _____

Has your child been injured participating in contact sports? (Soccer, Football, Martial Arts…) Y / N

Explain: _____

If yes, describe (Sprain, Broken Bone, Head Trauma…): _____

Has your child ever been involved in a car accident? Y / N Date & Injuries: _____

_____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y / N _____

Other traumas not described above? Y / N Type & Date: _____

Prior Surgery: Y / N Type & Date: _____

_____

_____

Prenatal History:

Location of Birth (check one): __Home __Birthing Center __Hospital __Stepchild __Adopted

Complications during pregnancy: Y / N List: _____

Ultrasounds during pregnancy/delivery: Y / N How many? _____

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

Cigarette/Alcohol use during pregnancy: Y / N Describe: _____

Complications during delivery: Y / N List: _____

Genetic disorders or disabilities: Y / N List: _____

Birth Weight: _____ Birth Length: _____ APGAR scores: 1 min_____ 5 min _____

Regarding your Birth Process:	[Please Describe if Applicable]	[Doctor's Comments]
Was the delivery long/difficult?	Y / N _____	_____
Forceps or Extraction used?	Y / N _____	_____
Cesarean/C-Section?	Y / N _____	_____
Breach/Cephalic?	Y / N _____	_____
Home Birth?	Y / N _____	_____
Hospital Birth?	Y / N _____	_____
Mother given drugs during delivery?	Y / N _____	_____
Was labor induced?	Y / N _____	_____

Feeding History:

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

Formula type: _____ Introduced to solids at _____ months. Cow's milk at _____ months

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

Developmental History:

Sleep (hours per night): _____ Naps: (number & lengths): _____ Problems sleeping: Y / N

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:
Check all that apply.

__HBV/Hep B (Hepatisis B)	Age: ____
__MMR (Measles, Mumps, Rubella)	Age: ____
__DTP or __DTaP (Diphtheria, Tetanus, Pertussis: DPT)	Age: ____
__Varicella (Chicken Pox)	Age: ____
__HbCV/Hib (H. influenza type b conjugate)	Age: ____
__PCV (Pneumoccocal)	Age: ____
__OPV (Oral Polio Vaccine)	Age: ____
__IPV (Inactivated Poliovirus)	Age: ____

Adverse reactions to any vaccine? Y / N Describe: _____

_____

_____

Insurance:

Do you have medical insurance? Y / N Insurance Company Name: _____

Policy Number: _____ Insurance Company Phone #: _____

Insured's Name: _____ Relationship to the patient: _____

Insured's DOB: _____ Insured's SS#:_____

Employer: _____ 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,_____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed: _____ Witnessed: _____

Date: _____