PEDIATRIC HISTORY
Birth to 2 Years

Please fill out this form as completely as possible as the doctor does review it prior to your consultation.

Today's Date _____

Child's Name: _____ Sex: M / F Date of Birth _____ Age _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____Cell: _____

Parent's Name 1: _____ Work Phone: _____

Parent's Name 2: _____ Work Phone: _____

Would you like our free monthly Wellness Newsletter by email? Yes / No email: _____

Whom may we thank for referring you to our office? _____

If your child is covered under an insurance policy, please name: _____

Purpose of today's appointment: _____

No. of siblings: _____

Birth Weight: _____ Current Weight: _____ Birth Length: _____ Current Height: _____

Type of birth (check all that apply): Normal Vaginal Forceps Vacuum Breech C-section Home

Birth Center / Hospital (name) _____

Obstetrician / Midwife: _____

Please list any traumas and or complications you experienced during your pregnancy? _____

_____

Any problems during labor/delivery? _____

APGAR Scores: _____ At birth, was there a presence of: Jaundice (yellow) cyanosis (blue)

Congenital anomalies/defects: _____

Siblings with same anomalies/defects? _____

Pediatrician (Name/ Location /Phone): _____

Date of last visit to MD: _____ Purpose: _____

During your pregnancy did you use: Tobacco Y / N Type:_____ Alcohol Y / N How much:_____

Prescribed Drugs Y / N Explain_____ OTC Drugs Y / N Explain:_____ Recreational Drugs_____

Infant Feeding – Please list at what age the child received each method. Breast _____ Bottle _____ Formula _____ Solids _____

Immunization History: _____

Has your child ever been treated on an emergency basis? Y / N Explain _____

PERSONAL HEALTH HISTORY - Has this child ever suffered from:

Colic	Dizziness	Poor appetite	Broken bones
Digestive trouble	Backaches	Hyperactivity	Hernia
Sinus trouble	Heart trouble	Concentration problems	Neck problems
Constipation	Diabetes	Behavioral problem	Arm problems
Bed-wetting	Tuberculosis	Convulsions	Leg problems "Growing Pains"
Anemia	Colds/Flu	Paralysis	Joint problems
Rheumatic Fever	High blood pressure	Muscle jerking	Blood disorders
Orthopedic problems	Headaches	Fainting	Stomach aches
Diarrhea	Asthma	Walking problems	Chronic Ear Infections

Surgeries: _____

Medications (prescribed or OTC) (name & purpose): _____

Allergies (Food/Seasonal/other): _____

No. hours sleep per night: _____ Quality of sleep: Good Fair Poor Explain: _____

Does your child go to sleep easily? Y / N Explain: _____

Does your child have a preferred sleeping position? Y / N Explain: _____

Does your child cry if you change this sleeping position? Y / N Explain: _____

Does your child have any feeding difficulties? Y / N Explain: _____

Is your child being breast fed? Y / N If no, for how long was baby breast fed _____ weeks/months.

Does your child have a one sided breast-feeding preference? Left / Right (Please circle one.)

Is your child formula fed? Y / N Which formula or other milk source?_____

Does your child frequently spit-up after feeding? Y / N Explain: _____

Does your child cry a lot? For how many hours each day? Y / N Explain: _____

Does your child pass a lot of intestinal gas? Y / N Explain: _____

Does your child have a preferred head position? Y / N Explain: _____

Does your child frequently arch his/her head and neck backwards? Y / N Explain: _____

Does your child cry or become irritable during a diaper change? Y / N Explain: _____

Has child ever had a fever? Y / N Explain: _____

Has your child had any falls? Y / N Explain: _____

Has your child been in a car accident or near-miss? Y / N Explain: _____

Has your child had any other trauma? Y / N Explain: _____

Does your child ever complain of headaches? Y / N Explain: _____

How frequently does your child have earaches?_____ Left / Right Ear

Do you have any other concerns you wish to discuss? Y / N Explain: _____

WELLNESS PROFILE

Chiropractic care affects more than our just muscles and bones. Please share with us what health goals you hope to achieve for your child. Check as many boxes as you wish.

improve overall health	more balance	more energy
better sports performance	try quality vitamins	better sleep
enhanced emotional	improve nutrition	freedom from pain
well-being	improved coordination	better concentration
other _____	reduce medications	easier breathing

Consent to Treat

I understand and agree that health and accident insurance policies are an arrangement between me and my insurance company and that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my conditions as he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. There is a $10.00 fee that will be charged for any and all missed office visits / adjustments and $20.00 for missed massage therapy visit. The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my child's physical health and the potential for improvement. Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining doctor deems necessary.

Parent's/Guardian's Name:_____Signature:_____

Date: _____ Witnessed by: _____