CONFIDENTIAL PEDIATRIC HEALTH HISTORY Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Birth Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Mother: _____ **Phone**: _____

Father: _____ **Phone**: _____

Best way to reach you? Home / Cell / Work / Email **Preferred patient reminders:** Email / Text

Email: _____ **Cell Phone**: _____ **Carrier**: _____

INFANTS AND NEWBORNS – HEALTH HISTORY

PRENATAL HISTORY

Name of Previous Chiropractor: _____

Birth Weight: _____ **Birth Length**: _____ **Full Term**? ❑ No ❑ Yes *(Describe):* _____

Complications during pregnancy? ❑No ❑ Yes *(Describe):* _____

Medications during pregnancy or delivery? ❑ No ❑ Yes *(List)*: _____

Cigarette/Alcohol/Drugs during pregnancy? ❑No ❑ Yes *(List)*: _____

Birth Interventions? ❑ No ❑ Forceps ❑ Vacuum ❑ Caesarian ❑Other _____

FEEDING HISTORY

Breast fed? ❑No ❑ Yes *(How Long?)* _____ **Formula fed?** ❑ No ❑ Yes *(How Long?)* _____

Introduced to cereal at _____ months old. **Introduced to solids at ____ months old**.

Food/Juice allergies or intolerances? ❑No ❑Yes *(Describe):* _____

DEVELOPMENTAL HISTORY

Sleep *(Hours per Night?)* _____ **Problems Sleeping?** *(Describe)* _____

HAS YOUR CHILD EVER SUFFERED FROM: (*Check all that apply)*

Pediatric
- ❑ ADHD
- ❑ Allergies/Asthma
- ❑ Autism
- ❑ Back/Neck Pain
- ❑ Bed Wetting
- ❑ Behavioral issues
- ❑ Chronic Earaches
- ❑ Colic
- ❑ Constipation
- ❑ Growing Pains
- ❑ Nightmares
- ❑ Reflux
- ❑ *None in this Category*

Childhood Diseases
- ❑ Chicken Pox: Age____
- ❑ Measles: Age____
- ❑ Meningitis: Age____
- ❑ Mumps: Age____
- ❑ Rubella: Age____
- ❑ Tuberculosis: Age____
- ❑ Whooping Cough: Age____
- ❑ Other: _____ Age____
- ❑ *None in this Category*

Has your child been vaccinated?
❑ No ❑ Yes
(Any Adverse Reactions? – Describe:)
_____

Current Medications: _____ Past Medications: _____

Surgeries: ❑ Ear Tubes left / right / both ❑ Tonsils / Adenoids ❑ Other: _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. _____ or whomever s/he may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ (minor patient's name).

Printed Name Parent/Guardian: _____ Witness: _____ Date: _____

Signature Parent/Guardian: _____ Date: _____

Consent for Treatment of Minor Child

Today's Date: _____

Patient Name: _____ Patient Date of Birth: _____

I hereby request and authorize Dr. _____and whomever he/she may designate, to perform diagnostic tests and render chiropractic care to the minor child named above.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

Witness: _____ Date: _____

Your Address Here