Pediatric History Form

Please complete these forms and return it 24 hours before your child's appointment

Date:_____

Child's Full Name:_____ Nickname:_____

Child's Date of Birth: _____ Age: _____

Child Height: _____ Child Weight:_____ Gender: Female____ Male____

Address: _____

Street Town State Zip

Mother/Guardian Name:_____ Phone:_____

Father/Guardian Name:_____ Phone:_____

Parent/Guardian Email Address: _____

Emergency Contact: _____Phone:_____

Insurance Company: _____

Insurance Identification Number: _____ Group Number: _____

Pediatrician Name: _____ When was child's last visit? _____

Pediatrician Phone: _____

May we contact your child's Pediatrician regarding your child's care if necessary? Yes_____ No_____

Has your child ever seen a Chiropractor before? Yes____ No_____ When was last visit?_____

Chiropractor's Name:_____

What is/are your chief concern(s) regarding your child's health?_____

_____

_____

Has your child seen any other Doctors/Professionals this condition? Yes_____ No_____

If yes, please explain:_____

_____

Is your child currently taking any medications or supplements? Yes____ No____ Please list:_____

_____

Is your child vaccinated: Yes_____ No_____ Does your child receive the flu shot? Yes_____ No_____ Date:_____

(If possible, please obtain a list from Pediatrician listing child's vaccinations to bring to appointment)

Has your child had any reactions to vaccinations? Yes____ No____ Explain:_____

Has your child ever taken antibiotics? Yes____ No____ Why?_____

Does your child exercise? Yes____ No____ Do you have concerns about your child's weight? Yes____ No____

Does your child carry a backpack? Yes____ No____ Do you feel that it is too heavy? Yes____ No____

What grade is your child in? _____ Have they ever stayed back? _____

Does your child attend daycare? Yes____ No____

Has your child ever broken a bone? Yes____ No_____ Explain: _____

Has your child every suffered any trauma? _____

Is there anything you want us to know about your child that will assist us with his/her care? _____

_____

_____

Health History: Has your child had or currently has any or the following conditions?

Past____ Current____ Asthma
Past____ Current____ Respiratory Tract Infections
Past____ Current____ Bronchitis
Past____ Current____ Sinus Problems
Past____ Current____ Ear Infections
Past____ Current____ Tonsillitis
Past____ Current____ Strep Throat
Past____ Current____ Frequent Colds/Croup
Past____ Current____ Recurrent Fevers
Past____ Current____ Eczema
Past____ Current____ Rashes
Past____ Current____ Allergies
Past____ Current____ Food Sensitivities
Past____ Current____ Digestive Problems
Past____ Current____ Frequent Diarrhea
Past____ Current____ Constipation
Past____ Current____ Stomach Pain
Past____ Current____ Depression
Past____ Current____ Anxiety
Past____ Current____ Walking on toes

Past____ Current____ Headaches
Past____ Current____ Neck Pain
Past____ Current____ Back Pain
Past____ Current____ Torticollis
Past____ Current____ Difficulty Eating
Past____ Current____ Bed Wetting
Past____ Current____ Growing Pains
Past____ Current____ Scoliosis
Past____ Current____ Colic
Past____ Current____ Frequent Crying
Past____ Current____ Failure to Thrive
Past____ Current____ Weight Challenges
Past____ Current____ Night Terrors
Past____ Current____ Sleep Problems
Past____ Current____ Seizures
Past____ Current____ Autism
Past____ Current____ ADHD
Past____ Current____ Behavioral Issues
Past____ Current____ Stress
Past____ Current____ Toes pointing inward/outward

Other: _____

Please explain any conditions you checked off: _____

_____

Birth History:

Where was your child born? Home_____ Hospital_____ Midwife_____ Adopted_____

Duration of gestation: _____Weeks Epidural? Yes____ No____

Was the birth assisted? Forceps_____ C-Section_____ Induced Labor _____ Vacuum____

Was the delivery normal? Yes____ No____ Explain: _____

Were there any problems during pregnancy? Yes____ No____ Explain:_____

Birth Weight: _____ Birth Length: _____ Length of Labor: _____ hours

Apgar score: 1 minute____ 5 minutes____ Unsure_____

Was child jaundice (yellow)?: Yes_____ No_____ Was child cyanotic (blue)? Yes____ No____

When did child roll over? _____Sit?_____ Crawl? _____ Walk? _____

Was the child breast fed? Yes_____ No_____ How long? _____

Does the child prefer to feed on one side? Yes_____ No_____ Which side?_____

Was the child diagnosed with "tongue-tied"? Yes____ No____

Did the child receive vaccinations after birth? Yes____ No____

Family History: Do any of the child's relatives have any of the following conditions?

Maternal____ Paternal____ Sibling____ Allergies
Maternal____ Paternal____ Sibling____ Cancer
Maternal____ Paternal____ Sibling____ Behavioral/Psychiatric Issues
Maternal____ Paternal____ Sibling____ Digestive Issues
Maternal____ Paternal____ Sibling____ Breathing Issues
Maternal____ Paternal____ Sibling____ Diabetes
Maternal____ Paternal____ Sibling____ Heart Conditions
Maternal____ Paternal____ Sibling____ Urinary Issues
Maternal____ Paternal____ Sibling____ Other: _____

What are you hoping to achieve by having your child adjusted? _____

_____

Do you and/or your spouse receive Chiropractic care? Yes (currently) _____ Yes (past)_____ No_____

I, _____, being the parent or legal guardian of _____,
(parent/guardian) (child)
hereby grant permission for my child to receive a Chiropractic evaluation as well as Chiropractic care which may include history, spinal scans, physical examination, manipulation, laser, heat/ice, ultrasound, therapeutic exercises, electrical stimulation or any service deemed medically necessary by West Hartford Chiropractic. I also understand that West Hartford Chiropractic cannot guarantee any results. I understand that I am responsible for any services received not covered by insurance and am responsible to obtaining a referral if required.