WEST HARTFORD
CHIROPRACTIC
the art of chiropractic

Pediatric History Form

Child's Full Name: _____ Age: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____ Gender: Female ☐ Male ☐

Address: _____

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 your child's last visit? _____

Pediatrician Phone: _____ May we contact them regarding your child's care? Yes ☐ No ☐

Has your child ever seen a Chiropractor before? Yes ☐ No ☐ Date of last visit? _____

Chiropractor's Name: _____

Do you and/or your spouse/partner receive Chiropractic care? Yes (currently) ☐ Yes (past) ☐ No ☐

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

Is there anything you want us to know about your child that will assist us with their care?

Health History:

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

Has your child seen any other Doctors/Professionals for this condition? Yes No

Is your child currently taking any medications or supplements? Yes No

If yes, please list:

Is your child vaccinated: Yes No Does your child receive the flu shot? Yes No Date:

Has your child had any reactions to vaccinations? Yes No Explain:

Has your child ever taken antibiotics? Yes No Why?

Do you have concerns about your child's weight? Yes No

Does your child attend daycare? Yes No

Has your child ever broken a bone? Yes No Explain:

Has your child had or currently have any of the following conditions?

Condition	Past	Current	Condition	Past	Current
Asthma			Headaches		
Respiratory Tract Infection			Neck pain		
Bronchitis			Back pain		
Sinus Problems			Torticollis		
Ear Infections			Difficulty Eating		
Tonsillitis			Bed Wetting		
Strep Throat			Growing Pains		
Frequent Colds			Scoliosis		
Recurrent Fevers			Colic		
Eczema			Frequent Crying		
Rashes			Failure to Thrive		
Allergies			Weight Challenges		
Food Sensitivities			Night Terrors		
Digestive Problems			Sleep Problems		
Frequent Diarrhea			Seizures		
Constipation			Autism		
Stomach Pain			ADHD		
Walking on Toes			Toes pointing inward/outwards		

Birth History:

Where was your child born? Home Hospital Adopted

Duration of gestation: Weeks Epidural? Yes No

Was the birth assisted? Induced Labor Forceps C-Section 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

Was your child diagnosed with "tongue-tie"? Yes No

When did your child: Roll over? Sit? Crawl? Walk?

Was your child breast fed? Yes No How long?

Does your child prefer to feed on one side? Yes No Which side?

Did your child receive vaccinations after birth? Yes No

Family History:

Do any of your child's relatives have any of the following conditions?

Condition	Maternal	Paternal	Sibling
Allergies			
Cancer			
Behavioral/Psychiatric Issues			
Digestive Issues			
Breathing Issues			
Diabetes			
Heart Conditions			
Urinary Issues			
Other			

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 for obtaining a referral if required.