STUBBENDIECK CHIROPRACTIC
PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients! To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#_____

Address: _____ City:_____State:_____

Zip:_____ Home/Cell Phone: _____Cell phone provider:_____

Birth Date: _____/_____/_____ Sex:_____ Weight:_____ Height:_____

Who may we thank for referring you to our office?:_____

Names of Parents/Guardians:_____

Purpose For Contacting Us?_____

Other Doctors Seen for this Condition (circle): Y / N Doctors' Names and Prior Treatments_____

_____

Other Health Problems? _____

Circle any of the Following Conditions Your Child has Suffered from During the Past Six Months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing/Back Pains
Colic	Bedwetting	Car Accident	Temper Tantrums	Other_____

Family History:_____

Name of Obstetrician/Midwife and/or Doula:_____

Previous Chiropractor: _____ Date of Last Visit: ____/_____/_____

Reason:_____

Name of Pediatrician/Family MD: _____Date of Last Visit: _____/_____/_____

Reason: _____

Number of Doses of <u>Antibiotics</u> Your Child Has Taken:

During the past 6 months:_____, Total During Lifetime: _____

Number of Doses of <u>Other Prescription Medications Your Child Has Taken:</u>

During the Past 6 months: _____, Total During Lifetime: _____ List:_____

_____

Prenatal History:

Complications During Pregnancy (circle): Y / N Explain: _____

Ultrasounds During Pregnancy (circle): Y / N Number: _____

Medications During Pregnancy/Delivery (circle all that apply):

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None (completely natural) Epidural Pitocin Other, please list:_____

Cigarette/Alcohol/Drug Use During Pregnancy (circle): Y / N List:_____

Location of Birth: _____ Length of Labor: _____

Birth Intervention (circle): Forceps Vacuum Extraction C-Section Emergency or Planned?_____

Complications During Delivery (circle): Y / N Explain:_____

Genetic Disorders or Disabilities (circle) Y / N Explain:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores (5 & 10 mins)_____ , _____

Feeding History:

Breast Fed (circle): Y / N For how long?:_____ Formula Fed (circle): Y / N For how long?:_____

Type of Formula: _____ Introduced to Solids at: _____Months

Cow's Milk at _____ Months Food/Juice Allergies of Intolerances: Y / N List:_____

_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____Respond to Sound _____Hold Head Up _____Cross Crawl _____Walk Alone

_____Respond to Visual Stimuli _____Sit Up _____Stand Alone

Has your child fell head first from a high place during their first year of life i.e. a bed, changing table, down stairs, etc.?
Y / N Explain:_____

Has your child been involved in any high impact or contact type sports? Y / N
List:_____

Has your child been involved in a Car Accident (circle)?: Y / N List:_____

Has Your Child Been Seen on an Emergency Basis?: Y / N List:_____

Other Traumas Not Described Above: _____

Prior Surgeries: _____

Menarche: Y / N Age: _____

Childhood Diseases:

Chicken Pox: Y / N Age_____ Mumps: Y / N Age_____

Rubella: Y / N Age_____ Whooping Cough: Y / N Age_____

Rubeola: Y / N Age_____ Other: Y / N Age_____