

Pediatric History Form

Central Connecticut Chiropractic welcomes you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. 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 Phone: _____

Birth Date: ____ / ____ / ____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose for Contacting Us? _____

Has the patients seen other Doctors for this condition?: YES NO

Doctor's Name and Prior Treatments: _____

Does the patient have any other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | | |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizure | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: ____ / ____ / ____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: ____ / ____ / ____ Reason: _____

Are you satisfied with the care you child has received there? YES NO

Number of Doses of **Antibiotics** your child has taken:

During the past six months: _____, Total during his/her lifetime: _____

Number of Doses of **Other Prescription Medications** Your Child has Taken:

During the Past Six Months: _____ Total During His/Her lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy? YES NO List: _____

Ultrasounds during pregnancy? YES NO Number: _____

Medication during pregnancy/delivery? YES NO List: _____

Cigarette/Alcohol use during pregnancy? YES NO

Location of Birth: Hospital Birthing Center Home

Birth intervention: Forceps Vacuum Extraction Cesarean Section, (Emergency or Planned?)

Complications during delivery? YES NO List: _____

Genetic Disorders or disabilities? YES NO List: _____

Birth Weight: _____ Birth Length: _____ APGAR scores: _____, _____

Feeding History:

Breast Fed? YES NO How Long?: _____

Formula Fed? YES NO How Long? _____ Type: _____

Introduced to solids at: _____ Months, Cows' Milk at _____ Months

Food/Juice allergies or Intolerances: YES NO 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 (sinus nerve interference). At what age was your child able to:

_____ Respond to sound	_____ Cross Crawl
_____ Respond to visual stimuli	_____ Stand Alone
_____ Hold head up	_____ Walk Alone
_____ Sit up	

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e.: bed, changing table, down stairs, etc.). Was this the case with your child? YES NO

Is / has your child been involved in any high impact or contact type sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? YES NO List: _____

Has your child ever been involved in a car accident? YES NO List: _____

Has your child been seen on an emergency basis? YES NO List: _____

Other traumas not described above? YES NO List: _____

Prior surgery? YES NO List: _____

Menarche? YES NO Age: _____

Childhood Diseases:

Chicken Pox Age: _____

Mumps Age: _____

Rubella Age: _____

Whooping Cough Age: _____

Rubeola Age: _____

Other Age: _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: _____