Confidential Pediatric Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Child's Name: _____ Date: _____
Mother's Name: _____ Father's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____ Email Address: _____
Who referred you to our office? _____
How else did you hear about us? _____

Date of birth: _____
Gender: _____
Child's Social Security Number *(if known):*
_____
Parent's Social Security Number *(just one):*
_____

Birth Weight: _____
Birth Length: _____

Current Weight: _____
Current Length/Height: _____

Birth History: *(please check all that apply)*

□ Home
□ Birth Center
□ Hospital
□ Vaginal
□ Cesarean

□ Forceps
□ Vacuum
□ Normal (face down)
□ Posterior occiput (face up)
□ Breech

□ Epidural Anesthesia
□ IV Anesthesia
□ Oral Pain Drugs
□ Pitocin
□ Other drug/intervention: _____
_____

Hours of labor: _____
Name of obstetrician/midwife: _____

Nutrition: *(please check all past & present and list the age/ length of time for each)*

Past:	Present:		Age/ Length of time:
□	□	Breast	_____
□	□	Bottle (breast milk)	_____
□	□	Formula	_____
□	□	Solid Foods	_____

Medical Intervention:

Vaccination History (please check all that apply):

(1)	(2)	(3)	
□	□		MMR
□	□	□	DTaP
□	□	□	Polio
□	□	□	Hepatitis B
□	□	□	Pediarix (DTP/Polio/Hep B)

(1)	(2)	(3)	(4)	
□	□	□	□	Haemophilus Influenzae Type B (Hib)
□	□	□	□	Pneumococcus
□	□			Chicken Pox
□				Influenza (number of times: _____)

How many prescriptions of antibiotics has your child taken in the last 6 months? _____
How many antibiotics in his/her lifetime? _____
Please list any other prescription medications your child has taken in the last year:
_____

Name of pediatrician: _____

Please indicate if you child has had any of the following symptoms or diagnoses in the past year or in their lifetime and any treatment they received for it.

Past year:	Lifetime:		Treatment:
□	□	Ear Infections	_____
□	□	Chronic colds/cough	_____
□	□	Recurrent Fevers	_____
□	□	Asthma	_____
□	□	Allergies	_____
□	□	Colic	_____
□	□	Stomach/digestive problems	_____
□	□	Constipation	_____
□	□	Diarrhea	_____
□	□	Bed Wetting	_____
□	□	Seizures	_____
□	□	Rashes	_____
□	□	Scoliosis	_____
□	□	ADHD	_____
□	□	Learning Disorder	_____
□	□	Temper Tantrums	_____
□	□	Sleeping Problems	_____
□	□	Headaches	_____
□	□	Autism	_____
□	□	Other (please explain):	_____

Chiropractic Care:
What is your primary concern for your child's health? _____
Any secondary concerns? _____
Anything else you would like the doctor to know about your child? _____
_____

Doctors of chiropractic remove interference to the transmission of nerve messages from the brain to the body and the body to the brain, by giving a chiropractic adjustment to the spine. This allows your child's body to heal with its maximum potential. Although this is our first priority, there are other health considerations that we would be glad to discuss with you and/or provide resources for you to obtain more information. Please circle the topics you would like to learn more about for your child:

Nutrition Physical Activity Sleep Stress Environmental Toxins
Medications Vaccinations Other (please list): _____

Authorization for care of a minor: I hereby authorize this office and its Doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent/guardian).

Parent's signature: _____ **Date:** _____