CHILD/ INFANT HISTORY FORM

Welcome to our family chiropractic office. Please let us know any suggestions you may have to improve our service to you and your family. Please complete the following information for each child that's to be seen today. We are eager to work with you to improve and maintain optimum health for you and your family.

Child Name______________________________ S.S.#______________
Address:______________________________ City:______________
State:______________ Zip:______________ Home Phone:______________
Birth Date:______________________ Work Phone:______________
Sex______ Weight:________ Height:________ Referred By:______________
Names of Parents/Guardians:______________________________

Reason For Contacting Us?______________________________
Other Doctors Seen for this :________N________Y, Doctors' Names and Prior Treatments:______________
____
____
Other Health Problems?______________________________
____

Check any of the Following Conditions Your Child has Suffered from during the past six months:

- ☐ Ear Infections
- ☐ Scoliosis
- ☐ Seizures
- ☐ Chronic colds
- ☐ Headaches
- ☐ Asthma or Allergies
- ☐ Digestive Problems
- ☐ ADD/ADHD
- ☐ Recurring Fevers
- ☐ Growing/bone/back pains
- ☐ Colic
- ☐ Bed Wetting
- ☐ Car Accident
- ☐ Head Banging
- ☐ Other______________

Family History:______________________________

Previous Chiropractor:______________ city______________ state______________
Date of Last Visit:______________, Reason:______________

Name of Pediatrician:______________________________
Date of Last Visit:______________, Reason:______________
Are you satisfied with the care your child received there?________N________Y

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?________N__________Y, List:______________
Ultrasounds during pregnancy?________N__________Y, Number:________
Medications during pregnancy/delivery?________N__________Y, List:______________
Cigarette/ Alcohol use during Pregnancy: ________N________Y
Location of Birth:__________Hospital ________Birthing Center ________Home

Birth Intervention:________ Ptocin ________Epidural ________Forceps ______ Vacuum Extraction
________Ceasarian Section, Emergency or Planned?
Complications during delivery or at birth? _______N ________Y List:________________________________
Genetic Disorders or disabilities?___________N_________Y, List:________________________________
Birth Weight:_______ Birth Length:_________ APGAR Scores:________, _________

Feeding History:
Breast Fed: _________N, ________Y, How Long: _________
Formula Fed:_________N, ________Y, How Long: _________ Type:________________________________
Introduced to solids at:________months, Cow's milk at _________months
Food / Juice allergies or intolerances: ________N ________Y, List:________________________________

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Developmental History:
At what age was your child able to:

___________Respond to Sound	________________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 their first year of life. Was this the case with your child?_________N _______Y, List________________

Is/has your child been involved in any high impact or contact type sports (ie., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ________N ________Y, List:________________________________

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Has your child ever been involved even in a "minor" accident?_______, N _______Y, List:________________

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Has your child been seen on an Emergency Basis?________N ________Y, List:________________________
Other Traumas Not described above? _______N ________Y, List:________________________________
Prior Surgery:_______N ________Y, List:____
Menarche:_________N ________Y, Age:___________

Childhood Diseases:

Chicken Pox	N / Y, Age______	Mumps	N / Y, Age _______
Rubella	N / Y, Age______	Whooping Cough	N / Y, Age________
Rubeola	N / Y, Age______	Other	N / Y, 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, including exams, Xrays and adjustments. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.
Signed:________________________________Witnessed__________________________Date______________