Pediatric History Form

Patient Demographics

Child's Name_____ Today's Date_____
Date of Birth_____ Birth Height _____Birth Weight _____Current Height_____
Current Weight _____ Age _____
Address_____City_____
State _____Zip _____ Phone _____Email_____
Mother's Name _____DOB _____
Father's Name _____DOB _____
Pediatrician_____City & State_____
Last Visit _____ Reason for visit _____

Purpose of this visit: _____Wellness check-up _____Injury or accident _____Other
Please explain _____

Birth History

Type of Birth: _____Normal Vaginal _____Forceps _____Breech _____Cesarean
_____Suction/Vacuum Extraction _____Pre-mature _____Full-term
Place of Birth: _____Hospital _____Birthing Center _____Home _____Other
Complications during pregnancy? _____
Complications during labor/delivery? _____
APGAR Scores _____ _____ _____Jaundice (yellow) _____Cyanosis (Blue)
Surgeries? _____
Medications? _____
Childhood diseases: ___Chicken pox ___Measles ___Mumps ___Rubella ___Whooping cough

If your child is experiencing Pain/Discomfort please identify where and for how long?
_____
_____
When did the problem first begin? Date ___/___/___ ___Unknown ___Gradual ___Sudden
Had this problem before? ___Yes ___No If Yes, when? _____
Number of doses of Antibiotics: In the Past 6 Months: ____During His or Her Lifetime: ____
Any bowel or bladder problems since this problem began? ___Yes ___No
If Yes, please describe _____
Have you seen any other doctors for this problem? ___Yes ___No
If Yes, who? _____
How long ago? _____
What were the results of past treatment? _____

How is this problem now? ___Rapidly improving ___Improving slowly ___About the same
___Gradually worsening ___ On and off
Is child taking any medications/supplements?: _____

Has your child ever sustained an injury playing organized sports? __Yes __No
If Yes, Please explain _____
_____
Has your child ever sustained an injury in an auto accident? __Yes __No
If Yes, please explain _____

Has your child ever suffered from:

__Headaches	__Orthopedic problems	__Digestive problems	__Behavioral problems
__Dizziness	__Neck problems	__Poor appetite	__ADD/ADHD
__Fainting	__Arm problems	__Stomach aches	__Ruptures/Hernia
__Reflux	__Seizures/Convulsions	__Leg problems	__Muscle pain
__Constipation	__Heart trouble	__Joint problems	__Growing problems
__Backaches	__Chronic earaches	__Diarrhea	__Bed Wetting
__Hypertension	__Sinus trouble	__Poor posture	__Asthma
__Scoliosis	__Anemia	__Colds/Flu	__Walking trouble
__Colic	__Bed wetting	__Broken bones	__Sleeping problems
__Fall from bed or couch		__Fall in baby walker	__Fall off slide
__Fall from changing table		__Fall from crib	__Fall off swing
__Fall off bicycle	__Fall from high chair	__Fall down stairs	__Fall off monkey bars
__Fall off skateboard/skates		__Epilepsy	__Autism
__Adverse reaction to vaccinations		__Diabetes	__Other_____

__Allergies _____

Surgical History/Hospitalizations:_____

I understand that I am directly and fully responsible to Dr. Jennifer Hickey for all fees associated with chiropractic care my child receives.

The risks associated with spinal adjustment have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's signature Date

_____ _____

Doctor signature Date