Pediatric History Form

Patient Name____ Age_________
Name of Parents / Guardians____
Address ________________________________City _______________State _____ Zip____________
Home Phone_______________ Work Phone_________________ Email___________________________
Patient Birth Date ___________ Gender______ Weight___________ Height_______
How did you hear about us? ____

Reason for seeking chiropractic care**:**____
How long has this been going on? ____
Other professionals seen for this condition? Y/N
If yes, who was seen and what was the treatment and outcome?
____
Other Health Problems/ Concerns:
____
Symptoms: Please check any current or past problems your child has on the list below:

_ADHD
_Hyperactivity
_Behavioral Issues
_Sensory Issues
_Chronic Earaches
_Frequent illness
_Headaches
_Dizziness
_Fainting
_Asthma

_Allergies
_Neuritis
_Sinus Trouble
_Cough/Wheeze
_Chest Pain
_Poor Memory
_Insomnia
_Nightmares
_Bed Wetting
_Pain Urinating
_Seizures

_Muscle Pain
_Broken bones
_Sprains/Strains
_Hernias
_Neck Pain
_Back Pain
_Arm/Elbow Pain
_Leg/Hip Pain
_Knee/Foot Pain
_Growing pains
_Joint Pain

_Scoliosis
_Digestive issues
_Constipation
_Diarrhea
_Poor Appetite
_Stomach Aches
_Diabetes
_Hypertension
_Other

Health History:
Name of Pediatrician: ____
Medications and conditions being treated:
____
Has your child ever taken antibiotics? Y/N Date last taken _____________________________________
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…)
____
Has your child ever been involved in a car accident? Y/N Date & Injuries
____
Other traumas not described above? Y/N Type & Date:
____
Prior surgery: Y/N Type and Date:
____