Pediatric Health History

Dear New Patient,

It is a pleasure to welcome 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. Research is showing that many of the health challenges that occur later in life have their origins during the developmental years some starting at birth. Please answer the following questions to the best of your ability. We look forward to assisting you and your family in reaching your full health potential.

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: (H) _____ (W) _____

Sex: _____ Weight: _____ Height :_____
Date of Birth: _____ (Age _____)
Social Security #: _____
Referred By: _____

Names of Parents/Guardians: _____

Purpose For Contacting Us? _____
Other Doctors seen for this condition: _____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
❒ Asthma/ Allergies	❒ Digestive Problems	❒ ADHD	❒ Recurring Fevers
❒ Colic	❒ Bed Wetting	❒ Car Accident	❒ Temper Tantrums
❒ Headaches	❒ Growing/ Back Pains	❒ Loss of Smell/Taste	❒ Other_____

Family History Notes: _____

Previous Chiropractor: _____
Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____
Date of Last Visit: _____ Reason: _____
Are you satisfied with the care your child has received there? _____N _____Y

Number of doses of Antibiotics your child has taken:
During the Past Six Months:_____, Total during His/Her Lifetime:_____, List:_____

Vaccination History:

❒ HBV / Hep B (Hepatitis B)
❒ __DTP or __DTaP [Diphtheria, Tetanus, (acellular) Pertussis]
❒ HbCV / Hib (H. influenzae type b conjugate)
❒ __OPV (Oral Polio Vaccine) or __IPV (Inactivated Poliovirus)
❒ MMR (Measles, Mumps, Rubella)
❒ Varicella (Chicken Pox)
❒ PCV (Pneumoccocal)

Adverse Reaction to Any Vaccine? ___N ___Y, List: _____

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: _____Forceps _____Vacuum Extraction _____Ceasarian Section, (Planned or Emergency?)
Complications during delivery? _____N _____Y, List:_____
Genetic Disorders or Disabilities? _____N _____Y, List:_____
Birth Weight: _____ Birth Length: _____ APGAR Scores:_____ , _____

(Continued)

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 tolerances: _____N _____Y, 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 (spinal nerve interference). At what age was your child able to:

_____Respond to sound
_____Respond to visual stimuli
_____Hold head up
_____Sit up
_____Cross crawl
_____Stand alone
_____Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life (i.e., a bed, changing table, down stairs, etc.) . Was this the case with your child? _____N _____Y

Is/ has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____N _____Y, List:_____
_____

Has your child ever been involved in a Car Accident? _____N _____Y, List: _____
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 Age_____
❒ Rubella Age_____
❒ Rubeola Age_____
❒ Mumps Age_____
❒ Whooping Cough 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 Health & Wellness Solutions Family Chiropractic and Dr. Sanchez 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 charged for services provided by this office.

_____ _____
Signature Date

_____ _____
Witness Date