# PEDIATRIC HISTORY FORM (ages 6 and under)

**CONFIDENTIAL PATIENT INFORMATION:** **DATE:**

CHILD'S NAME:_____ DOB:_____ AGE:_____ Gender:_____

ADDRESS:_____ CITY: _____ STATE: _____ ZIP CODE:_____

MOTHER'S NAME: _____ HOME PHONE:_____

FATHER'S NAME: _____ ALTERNATE PHONE:_____

PARENT'S SOCIAL SECURITY NO:_____ PCP NAME(of CHILD):_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?:_____ REFERRED BY:_____

Do you have health insurance for this child?:_____ Ins Company?:_____ Policy#:_____

Name of employee:_____ Employee's SS#:_____ Employer:_____

I hereby authorize Dr. Stephan and whomever he may designate as his associate to administer chiropractic care as he deems necessary. Nearly all insurance policies provide chiropractic coverage, but benefits vary for each company/policy. Therefore, if we have insurance that the Chiropractic Family Health Center accepts, we will utilize their billing service. I will be personally responsible for payment of all services not covered by our insurance. X-rays remain the property of this clinic.

_____

Signature of parent or guardian Relationship to child

**WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR AND YOUR CHILD'S RESULTS.**

## PATIENT CASE HISTORY:

**Purpose for this appointment:**_____

Other doctors seen for this condition and the treatment provided:_____

_____

Family history:_____

Previous chiropractor:_____ Date of last visit:_____

Name of pediatrician:_____ Date of last visit:_____

Number of doses of antibiotics your child has taken in the last six months:_____ during lifetime:_____

Number of doses of other prescription medications your child has taken during the last six months:_____

Total during his/her lifetime:_____ List prescriptions:_____

Vaccination history:_____

**Check any of the following conditions your child has experienced:**

| | | |
|---|---|---|
| _____ADHD | _____ Digestive problems | _____Recurring fevers |
| _____Asthma/Allergies | _____ Ear infections | _____Scoliosis |
| _____Bed wetting | _____Growing/back pains | _____Temper Tantrums |
| _____Chronic colds | _____Headaches | _____Other |
| _____Colic | _____Hyperactivity | _____Other |

**Prenatal History:**

Name of obstetrician/midwife:_____

Complications during pregnancy?: _____Y _____N, List:_____

Ultrasounds during pregnancy?:_____Y_____N How many?:_____

Medications during pregnancy/delivery?:_____Y_____N, List:_____

Cigarette/alcohol/drug use during pregnancy?:_____Y_____N

Location of Birth?:_____hospital_____birthing center_____home delivery

Birth intervention?: _____forceps _____vacuum extraction _____breech birth

_____caesarian section, _____emergency, or_____ planned

Complications during delivery?:_____Y_____N, List:_____

Genetic disorders or disabilities?:_____Y_____N,List:_____

Birth weight:_____Current weight:_____Birth length:_____APGAR scores:_____,_____

Jaundice (yellow):Y_____N_____ Cyanosis (blue):Y_____N_____

**Feeding History:**

Breast fed:_____Y_____N, How long:_____ Formula fed:_____Y_____N, How long:_____

Introduced to solids at _____months. Introduced to cows' milk at _____months.

Food/Juice allergies or intolerances:_____Y_____N, 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 year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?:____Y____N

Has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?:_____Y_____N, List:_____
Has your child ever been involved in a car accident?:_____Y_____N, List:_____
Other traumas not described above?:_____Y_____N, List:_____
Prior surgery:_____Y_____N, List:_____

**PLEASE DO NOT WRITE IN THE SPACE BELOW**