Pediatric New Patient Health History Form

Please complete this form as accurately as possible. Your answers will help us to determine whether chiropractic can help your child.

Child's Name:_____ Current Date: _____

☐ Male ☐ Female Birth Date: _____ Age: ____ Social Security #: _____

Mother's Full Name: _____ Father's Full Name: _____

Address:_____ City:_____ State: _____ Zip: _____

Phone # (Home): _____ (Work): _____ Email:_____

_____

Number of Siblings: _____ Name(s): _____

Purpose of Today's Appointment:_____

_____ Referred By:_____

Do You Intend to Use Insurance? ☐ Yes ☐ No If Yes, Please Present Your Insurance Card to the Front Desk

Other Treating Physicians

Obstetrician/Midwife (Name): _____ (Location):_____

Pediatrician/Family MD (Name):_____ (Location):_____

Date of Last Visit:_____ Purpose of Visit: _____

Previous Chiropractor (Name): _____ (Location):_____

Date of Last Visit:_____ Purpose of Visit: _____

Immunization History:_____

Number of Doses of Antibiotics: In the Past 6 Months _____ During His/Her Lifetime _____

Is Child Currently On Any Medications/Supplements: ☐ Yes ☐ No If Yes, Please List Name and Condition:

_____

Has Your Child Ever Been Treated in an Emergency? ☐ Yes ☐ No If Yes, Please Explain:_____

_____

Birth History

Term: ☐ Full Term ☐ Pre-mature Birth Weight: _____ Birth Length: _____

Type of Birth: ☐ Normal Vaginal ☐ Forceps ☐ Breech ☐ Cesarean ☐ Suction/Vacuum Extraction

Place of Birth: ☐ Hospital ☐Birthing Center ☐ Home ☐ Other, Please Explain: _____

Complications During Pregnancy: _____

Complications During Labor/Delivery: _____

APGAR Scores: _____ _____ Was There Presence at Birth of: ☐ Jaundice (yellow) ☐ Cyanosis (blue)

Congenital Anomalies/Defects? ☐ Yes ☐ No If Yes, Please Explain:_____

Health History

Current Weight: _____ Current Length: _____

Infant Feeding: ☐ Breast ☐ Bottle ☐ Formula, if so which formula? _____

Number of Hours of Sleep per Night: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Developmental History

Please List the Age at Which Your Child Did the Following Activities

_____ Respond to Sound _____ Follow an Object with His/Her Eyes _____ Hold Head Up

_____ Sit Alone _____ Crawl _____ Stand Alone _____ Walk Alone

Childhood Diseases

Please List Age if Applicable

☐ Chickenpox _____ ☐ Mumps _____ ☐Measles _____ ☐ Rubella _____

☐ Rubeola _____ ☐ Whooping Cough _____ ☐ Other, Please Explain: _____

Has Your Child Ever Suffered From

Check All That Apply

☐ Headaches	☐ Dizziness	☐ ADD/ADHD	☐ Autism	☐ Behavioral Problems
☐ Neck Problems	☐ Poor Appetite	☐ Fainting	☐ Stomach Aches	☐ Chronic Earaches
☐ Arm Problems	☐ Leg Problems	☐ Joint Problems	☐ Seizures	☐ Ruptures/Hernias
☐ Reflux	☐ Heart Trouble	☐ Constipation	☐ Diarrhea	☐ Growing Pains
☐ Muscle Pain	☐ Backaches	☐ Poor Posture	☐ Diabetes	☐ Sinus Infections
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Colds/Flu	☐ Trouble Walking
☐ Anemia	☐ Colic	☐ Broken Bones	☐ Bed Wetting	☐ _____
☐ Allergies to:_____				☐ _____

Has Your Child Ever Suffered Any of the Following Traumas to His/Her Spine

Check All That Apply

☐ Fall From Crib ☐ Fall From Bed/Couch ☐ Fall From Baby Walker ☐ Fall From Changing Table

☐ Fall From High chair ☐ Fall Off Swing ☐ Fall off Bicycle ☐ Fall Off Slide

☐ Fall Down Stairs ☐ Other Traumas/Falls: _____

Medical History

Has Your Child Ever Sustained an Injury Playing Sports? ☐ Yes ☐ No If Yes, Please Explain: _____

_____

Has Your Child Ever Been in an Auto Accident? ☐ Yes ☐ No If Yes, Please Explain: _____

_____

Present Medical History: _____

_____

Surgical History/Hospitalizations: _____

_____

Family History:_____

_____

I certify that I am the parent or legal guardian of the child and the above information is accurate and complete. Fletcher Chiropractic or its doctors will not be held liable for incorrect or withheld information.

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian Signature Date