

Pediatric History Form

Jenkins Chiropractic welcomes 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. To help us serve you better, please complete the following information. We look forward to working with you to improve the health of you and your family.

Patient Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Birth Date: _____ Sex: Male Female Weight: _____ Height: _____

Referred by: _____ Name of Parents/Guardians: _____

Purpose for contacting us? _____

Has the patient seen other doctor's for this conditions: Yes No

If yes, Doctor's name and Prior Treatments:

Does the patient have any other health problems?

Check any of the following conditions your child has suffered from in the past:

- | | | |
|---|--|--|
| <input type="checkbox"/> ear infections | <input type="checkbox"/> bed wetting | <input type="checkbox"/> recurring fever |
| <input type="checkbox"/> asthma/allergies | <input type="checkbox"/> seizure | <input type="checkbox"/> temper tantrums |
| <input type="checkbox"/> colic | <input type="checkbox"/> adhd | <input type="checkbox"/> headaches |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> car accident | <input type="checkbox"/> growing/back pain |
| <input type="checkbox"/> digestive problems | <input type="checkbox"/> chronic colds | <input type="checkbox"/> other |

Previous Chiropractor: _____

Date of last visit: _____ Reason: _____

Name of Pediatrician? _____

Are you satisfied with the care your child received there? Yes No

How many times has your child received antibiotics? _____ In the past 6 months?

Other prescription medications your child has taken: _____

Is your child current with all vaccinations? Yes No

Prenatal Histoy

Name of Obstetrician/Midwife:

Complications during pregnancy: Yes No List:

Ultrasounds: Yes No List:

Medications during pregnancy or delivery:

Cigarette/Alcohol us during pregnancy: Yes No

Locations of Birth: hospital birthing center home
Birth Intervention: forceps vacuum extraction c-section
Complications during delivery: Yes No List: _____
Genetic Disorders/Disabilities: Yes No List: _____
Birth Weight: _____ Birth Length: _____ APGAR Score: _____

Feeding History

Breast Fed: Yes No How Long: _____
Formula Fed: Yes No How Long: _____
Introduced to solids at _____ months Cow's Milk at _____ months
Food/Juice Allergies or Intolerances: Yes No List: _____

Developmental History

During the following times your child's spine is most vulnerable to stress and should routinely be check by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Respond to sound | <input type="checkbox"/> Cross Crawl |
| <input type="checkbox"/> Respond to visual stimuli | <input type="checkbox"/> Stand Alone |
| <input type="checkbox"/> Hold head up | <input type="checkbox"/> Walk Alone |
| <input type="checkbox"/> Sit up | |

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

Yes No

Is/has your child been involved in any high impact or contact sport? Yes No

List: _____

Has your child ever been involved in a car accident? Yes No List: _____

Has your child been seen on an emergency basis? Yes No List: _____

Other traumas: _____

Prior Surgery: _____

Menarche? _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZE FOR CARE OF MINOR

I hereby authorize this office and its doctors 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 by this office.

Name of Insurance Company: _____ Policy Number: _____

Date: _____ Guardian Name: _____

Signature: _____