Dear 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. To help better serve you, please complete the following information. We look forward to working with you to build better health for your family.

PEDIATRIC HISTORY FORM

Today's Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Name of Parents/Guardians: _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ e Left Handed e Right Handed

Address: _____

City: _____ State _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Who referred you to our office, or how did you hear about us? _____

Purpose for contacting our office? _____

Addressing the Issues that Brought Your Child to the Office

Briefly describe your main concern. *If you're here for wellness care please go to #11* _____

1) If you are experiencing a symptom, is it… (check more than one if necessary to describe your problem)

e Sharp e Dull e Burning e Numbness & Tingling e Pressure e Comes & Goes e Travels

e Constant

2) Where is the symptom? _____

3) When did the *symptom* first start? _____

4) Since the symptom started, it is…

e About the same e Getting Better e Getting Worse

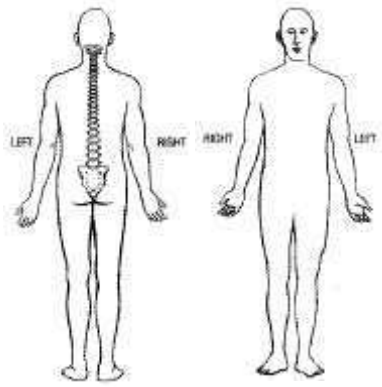
5) What makes it worse: _____

6) Yes, it interferes with: e Work e Sleep e Walking

e Sitting e Hobbies e Leisure

7) Does this cause you to be: e Irritable e Moody e Worried

8) Is your Condition: e Job Related e Auto Accident e Home Injury



Please outline on the diagram the area of your discomfort.

9) Other Doctors seen for this problem and when (please list):

e Chiropractor _____ e Medical Doctor _____ e Other _____

10) Drugs you now take: _____

11) Past Surgeries / Operations _____

Check any of the following conditions your child has suffered from during the past six months:

□ Ear infections □ Scoliosis □ Seizures □ Headaches □ Asthma/Allergies

□ Digestive Problems □ ADD/ADHD □ Recurring Fevers □ Colic □ Growing/Back Pains

□ Bed Wetting □ Car Accident □ Temper Tantrums □ Chronic Colds □

Other:_____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

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

---

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total during Lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ Total during Lifetime: _____

Please list: _____

Please, list your child's vaccination history:

_____

_____

Prenatal History:

Were there complications during pregnancy? □ No □ Yes, Explain:

_____

_____

Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section (Emergency or Planned)

Were there complications during the delivery? □ No □ Yes, Explain:

_____

_____

Birth Weight: _____ Birth Length: _____

Feeding History:

Breast Fed: □ No □ Yes; How long? _____

Formula Fed: □ No □ Yes; How long? _____

Developmental History:

Is / has your child been involved in any high impact or contact type sports (i.e. soccor, football, gymnastics, baseball, cheerleading, martial arts, etc)? □ No □ Yes; List:

_____

_____

Has your child been involved in a car accident? □ No □ Yes; Explain:

_____

_____

Has your child experienced any other traumas not described above? □ No □ Yes; Explain:

_____

_____

I hereby authorize this office and its Doctors to administer care to my child, as they deem necessary.

_____

Parent/Guardian Signature Date