Pediatric History Form

Patient Name_____ MSI_____

Name of Parents / Guardians_____

Address _____City _____Province _____Postal Code_____

Home Phone_____ Work Phone_____ Email Address_____

Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____

Who referred you to us? _____

Reason for seeking chiropractic care: _____

Other Doctors seen for this condition Y/N Specialty: _____

Prior treatment and outcome: _____

Other Health Problems: _____

Insurance

Do you have medical insurance? Y/N Insurance Company Name _____
Policy Number _____Insurance Company Phone number _____
Insured's Name _____Relationship to patient _____
Insured's DOB _____Insured's SS# _____
Insured's Employer _____ Insured's Employee Address_____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness
_Backaches
_Heart Condition
_Chronic Earaches
_Diabetes
_Tuberculosis
_Hypertension
_Fever/Chills
_Frequent Colds
_Headaches
_Asthma
_Allergies

_Runny Nose
_Itchy Eyes
_Rashes
_Unusual Moles
_Neuritis
_Digestive
_Sinus Trouble
_Cough/Wheeze
_Chest Pain
_Constipation
_Anemia
_Rheumatic Fever

_Diarrhea
_Poor Appetite
_Hyperactivity
_Behavioral
_Poor Memory
_Insomnia
_Nightmares
_Bed Wetting
_Pain Urinating
_Convulsions Paralysis
_Muscle Pain
_Fainting

_Broken bones
_Sprains/Strains
_Neck Pain
_Arm/Elbow Pain
_Leg/Hip Pain
_Knee/Foot Pain
_Growing pains
_Joint Pain
_Scoliosis
_Blood disorders
_Stomach Aches _Other

Health History:

Name of Doctor: _____ Date of last visit _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? Y/N Condition treated: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma..) _____

Has your child ever been involved in a car accident? Y/N Date & Injuries _____

Has your child ever fallen head first from (Changing Table, Bed, Stairs..) Y/N _____

Other traumas not described above? Y/N Type & Date: _____

Has your child been vaccinated Y/N

Feeding History

Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History
Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases
Chicken Pox - Age ___ Mumps - Age ___ Rubella - Age ___ Whooping cough - Age ___
Measles - Age ___ Meningitis - Age ___ Tuberculosis - Age ___ Other - Age _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____
hereby grant permission for my child to receive chiropractic care.

Signed _____Witnessed _____

Date _____