

**Pediatric Case History**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

*Please help us to understand as much about your child as possible. It is our mission to help every child express their full potential through Chiropractic care. Starting with a good foundation of knowledge about every single patient is imperative to achieve this mission.*

Purpose for contacting this office \_\_\_\_\_

Pediatrician's name \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Satisfied with Pediatrician? Yes  No  Other health problems \_\_\_\_\_

Family History \_\_\_\_\_ Previous Chiropractor \_\_\_\_\_

**Medications:** # of Antibiotics in past 6 months \_\_\_\_\_ Lifetime? \_\_\_\_\_ Other Meds? \_\_\_\_\_

Vaccinations: \_\_\_\_\_ Reactions? \_\_\_\_\_

Allergies / sensitivities to medications \_\_\_\_\_

**Prenatal History:** Name of Obstetrician/Midwife \_\_\_\_\_

Complications during pregnancy Yes  No  List \_\_\_\_\_

Complications during delivery Yes  No

Number of Ultrasounds during pregnancy \_\_\_\_\_ Medications during pregnancy \_\_\_\_\_

During pregnancy, did mother? Smoke Yes  No , Alcohol Yes  No , Caffeine Yes  No

Location of Birth: Hospital  \_\_\_\_\_ Home  Other  \_\_\_\_\_

**Birthing details:** Breech , Cessarian , Forceps , Vacuum extraction , Episiotomy , Natural

Medications during birthing process \_\_\_\_\_ Epidural Yes  No

Apgar Score \_\_\_\_\_ Birth Weight \_\_\_\_\_ Generic disorders / difficulties \_\_\_\_\_

**Feeding History:** Breast Fed Yes  No  If yes, how long? \_\_\_\_\_

Formula type? \_\_\_\_\_ Age solids introduced? \_\_\_\_\_ Food allergies / sensitivities \_\_\_\_\_

**Developmental History:** During certain stages of development your child's spine and nervous system are vulnerable to incredible stresses. During there periods Chiropractic checkups are most necessary.

Rolling over \_\_\_\_\_ Sitting up without support \_\_\_\_\_ Crawling \_\_\_\_\_

Standing with support \_\_\_\_\_ Walking unassisted \_\_\_\_\_

Trauma as an infant or toddler (falls from change table, stairs, accidents etc. \_\_\_\_\_

**Surgery**

Childhood diseases: Asthma  Croup  Ear infections  Chronic colds  Bronchitis

Chicken pox  Rubella  Rubeola  Mumps  Whooping Cough  ADHD  Allergies

Other \_\_\_\_\_

**Authorization:**

On behalf of this child as a parent or legal guardian, I consent to any and all care provided at this clinic under the appropriate scope of practice.

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date