Bearor Family Chiropractic
Pediatric History Form

Today's Date: ____________________

Child's Name: ____ S S #: ____________________ DOB: _____________

Male / Female (Circle one) Weight:______ lbs. Height: _____ft. ____in.

Address: ______________________________________City: _______________ State: ______ Zip: _______________

Parent/Guardian: ____

Phone #'s: Home _________________ Cell _______________ Referred by: __________________________________

Insurance provider: ______________________ • Present insurance card at Front Desk for copying •

Purpose for contacting our office? ____

Other Doctors seen for this condition? Y / N Doctor's names and prior treatments: _______________________

____

____

List other health problems: ____

Family history: ____

Check any of the following conditions that currently apply:

__ Ear Infections	__ Scoliosis	__ Chronic Colds	__ Headaches
__ Allergies	__ Digestive Problems	__ ADHD/ADD	__ Recurring Fevers
__ Colic	__ Growing/ Back Pains	__ Bed Wetting	__ Temper Tantrums
__ Seizures	__ Asthma	__ Car Accident: when? ___________	

Previous Chiropractic Care? Y / N Last Visit? _________________

Name of Pediatrician: _________________________________ Last Visit? ________________

Are you satisfied with the care you child has received at the pediatrician? Y / N

# of doses of antibiotics your child has taken: Past 6 months ___________ Total lifetime _____________

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

Past 6 months _______ Total lifetime _______ List: ____

Vaccination History: ____

____

Prenatal History - (circle all that apply)

Name of Obstetrician/midwife: ____

Complications during pregnancy/delivery? Y / N Explain: ___________________________________

Ultrasounds during pregnancy? Y / N How many? ___________

Medications taken during pregnancy/delivery? Y / N List: ____________________________________

Cigarette/Alcohol use during pregnancy? Y / N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: Emergency or Planned (circle one)

Genetic disorders/disabilities? Y / N List: ____

Birth Weight: _______________ Birth Length: _________________ APGAR Scores: ___________-___________

Pediatric History Form Continued

Child's Name:_______________________________________ DOB: _____________ Today's Date: ____________

Feeding History

Breast Fed: Y / N How long? _____________ Formula Fed: Y / N How long? __________ Type: _____________

Introduced to: Solid foods @ _______ Months Cow's milk @ _______ Months

Food/ Juice allergies or intolerances: Y / N List: ____

Developmental History

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

Respond to stimuli _________ Cross crawl ________ Stand alone ________

Respond to visual stimuli __________ Hold head up_______ Walk alone ________

Sit up _______

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did your child have a fall similar to what was described above? Y / N Explain: ____________________________

____

Has your child been involved in any high impact or contact sports? Y / N List: ____________________________

____

Has your child been seen by a physician on an emergency basis? Y / N Explain:___________________________

____

Other traumas not described above? ____

____

Lifestyle - please check what applies

Does your child: ä eat health food products (organic products, etc.) ä drink water

ä take vitamins Type:_________________________________ ä take probiotics

Exercise: änone ä moderate ä daily ä heavy

Hobbies/Interests: ____

____

Notes: ____

____

____

Parent/guardian name (please print): ____

Parent/guardian signature:_______________________________________ **Date:** __________________