Life Line Chiropractic

Pediatric History Form

Patient Name ____

Names of Parents/Guardians____

Child's Sex _______ Weight _______ Height _______

Chief Complaints

What is your main reason for bringing your child to Life Line Chiropractic today?

____

Have you taken your child to other physicians for this condition? N Y, please list__________________

What was the treatment given? ____

Please mark any current or past problems your child may have on the list below.

____ ear infections	____ scoliosis	____ seizures	____ chronic colds	____ headaches
____ allergies	____ digestive	____ ADHD	____ bed wetting	____ colic
____ anemia	____ growing pains	____ temper tantrums	____ asthma	____ fevers
____ behavioral	____ joint pain	____ diabetes	____ other	

Health History

Name of Pediatrician: ________________________________ Date of last visit _______________

Medications____

Has your child ever taken antibiotics? N Y, condition treated__________________________

Has your child been injured participating in contact sports? N Y, describe__________________________

Has your child ever been involved in a car accident? N Y, date & injuries ___________________

Other traumas not described above? N Y, type & date ______________________________

Prenatal History- Name of Obstetrician/Midwife ______________________________

Did you have complications during pregnancy? N Y, please list ___________________________

Were medications taken during pregnancy/delivery? N Y, please list ___________________________

Cigarette /alcohol use during pregnancy? N Y

Location of birth ______ hospital _______ birthing center _______ home birth

Intervention ___Forceps ___Vacuum Extraction ___Caesarian Section- Emergency or Scheduled

Genetic disorders or disabilities N Y, please list____________________________

Birth Weight ______ Birth Length ______ APGAR Scores _______

Family health history ____

Child's previous Chiropractor ______________________________________

Date of Last Visit _____ /_____/_____ Reason ______________________________

Are you satisfied with the care our child has received there? N Y

Vaccination History____

Feeding History Breast fed N Y, how long ______________

Formula fed N Y, how long ______________ type____________

Introduced to solids at ________ months

Cow's milk at ________ months

Food/juice allergies or intolerances N Y, list __________________________

What age was your child able to _____ respond to sound _____ cross crawl

_____ respond to visual stimuli _____ stand alone

_____ 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 (a bed, changing table, down stairs, etc.). Was this the case with your child? N Y, at what age______________________

Childhood Diseases Chicken Pox N Y, age_______ Mumps N Y, age _______

Rubella N Y, age_______ Whooping Cough N Y, age _______

Measles N Y, age_______ Other N Y, age _______

Do you have any additional information that is necessary for treatment of your child?

____

Signature ____ Dated _________________

Relationship to minor________________________________