

**3082 Dyer Blvd, Kissimmee, FL 34741**

**Office 407.329.3747/ Fax 407.264.6167**

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| **Pediatric History Form** |

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_

Name of Parents / Guardians\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of siblings\_\_\_\_\_\_\_\_\_\_  
Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_   
Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
How were you referred you to the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Reason for seeking chiropractic care**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other Doctors seen for this condition Y/N Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior treatment and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Other Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_Dizziness

\_ADHD

\_Backaches

\_Heart Condition \_Chronic Earaches   
\_Diabetes \_Tuberculosis \_Hypertension

\_Fever/Chills

\_Frequent Colds   
\_Arthritis

\_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

\_Hernias   
\_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 Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_   
Reason for 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Prior surgery: Y/N Type and Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Menarche: Y/N Age:\_\_\_\_\_\_\_\_   
**Prenatal History**   
Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted  
Complications during pregnancy: Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Cigarette / Alcohol use during pregnancy: Y/N   
Birth intervention: O Forceps O Vacuum O Caesarian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Complications during delivery: Y/N List: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   
Genetic disorders or disabilities: Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Feeding history**   
Breast Fed: Y/N How long’?\_\_\_\_\_\_\_\_\_\_\_ Formula fed: Y/N How long’?\_\_\_\_\_\_\_\_\_\_\_   
Introduced to solids at \_\_\_\_\_ months.

Food allergies or intolerances Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

