Pediatric History Form

(For Children 12 Years and Under)

WholeCare
A Transformational Chiropractic & Holistic Health Center

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients here at Whole Care. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to create better health for your family.

(Please Print)

Patient Name: ______________________ Name You Prefer Us To Use: ______________

Address: ______________________ City: __________ State: ______ Zip: ________

Home Phone: (______) ______________ Cell: (______) ______________

Date of Birth: ________ S.S.# ______-____-______ Gender: ☐ Female ☐ Male Weight: ______ Height: ______

Parent(s)/Guardian Name(s): ______________________ Referred By: ______________

Purpose for Contacting Whole*Care* ? ______________________

Have Other Doctors Been Seen for this Condition? ☐ Yes ☐ No If Yes, List Doctor Name(s) and Prior Treatments: ______________

____

Any Other Health Problems? ______________________

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

☐ Ear Infections	☐ Digestive Problems	☐ Car Accident	☐ Headaches
☐ Asthma / Allergies	☐ Bed Wetting	☐ Chronic Colds	☐ Growing / Back Pains
☐ Colic	☐ Seizures	☐ Recurring Fevers	☐ Autism
☐ Scoliosis	☐ ADD/ADHD	☐ Temper Tantrums	☐ Other: ________

Family History: ______________________

Previous Chiropractor (If Any): ______________________ Date of Last Visit: __________

Reason: ______________________ Are You Satisfied with the Care Your Child has Received There: ☐ Yes ☐ No

Name of Pediatrician: ______________________ Date of Last Visit: __________

Reason: ______________________ Are You Satisfied with the Care Your Child has Received There: ☐ Yes ☐ No

Number of **Antibiotics** Your Child has Taken During the Past Six Months: ______ During His/Her Lifetime: ______

Number of Doses of **Other Prescription Medications** Your Child has Taken During the Past Six Months: ______

During His/Her Lifetime: ______ Please List: ______________________

____

Vaccination History: ______________________

Prenatal History:

Name of Obstetrician/Midwife: ______________________

Complications During Pregnancy: ☐ Yes ☐ No List: ______________________

Ultrasounds During Pregnancy: ☐ Yes ☐ No Number: ______

Medications During Pregnancy/Delivery: ☐ Yes ☐ No List: ______________________

Cigarette/Alcohol Use During Pregnancy: ☐ Yes ☐ No

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section If C-Section: ☐ Emergency ☐ Planned

Complications During Delivery: ☐ Yes ☐ No List:______________________

Genetic Disorders or Disabilities: ☐ Yes ☐ No List:______________________

Birth Weight:__________ Birth Length:__________ APGAR Scores:________ ________

Feeding History:

Breast Fed: ☐ Yes ☐ No How Long? __________

Formula Fed: ☐ Yes ☐ No How Long?__________ What Type?______________________

Introduced to Solids at _____ Months Introduced to Cows' Milk at _____ Months

Food/Juice Allergies or Sensitivities: ☐ Yes ☐ No List:______________________

____

Developmental History:

During the following developmental stages your child's spine is most vulnerable to stresses 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 Sound:________ Respond to Visual Stimuli:________ Hold Head Up:________

Sit Up:________ Cross Crawl:________ Stand Alone:________ Walk Alone:________

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.). Has your child had a head-first fall? ☐ Yes ☐ No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)?

☐ Yes ☐ No List:______________________

Has Your Child Ever Been Involved in a Car Accident? ☐ Yes ☐ No List:______________________

Has Your Child Been Seen on an Emergency Basis? ☐ Yes ☐ No List:______________________

Other Traumas Not Described Above? ☐ Yes ☐ No List:______________________

Prior Surgery: ☐ Yes ☐ No List:______________________

Menarche: ☐ Yes ☐ No Age:__________

Childhood Diseases: Please mark all that apply.

☐ Chicken Pox Age:__________ ☐ Mumps Age:__________

☐ Rubella Age:__________ ☐ Whooping Cough Age:__________

☐ Rubeola Age:__________ ☐ Other(s) List:______________________

We are here to serve you and we encourage you to ask questions. Your participation is vital and will help determine your child's results.

Authorization for Care of Minor

I hereby authorize Whole*Care*, its Doctors and Staff to administer Chiropractic care to my Son/Daughter as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of Parent/Guardian:______________________ Date: __________

Signature of Parent/Guardian:______________________

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