

## Confidential Pediatric Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Child's Name: Father's Name: Stather's Name: S	Child's Name:			Date:			
City, State, Zip Code:  Home Phone:  Who referred you to our office?  How else did you hear about us?  Date of birth:  Gender:  Child's Social Security Number (if known):  Birth Length:  Current Weight:  Current Length/Height:  Birth History:  (please check all that apply)  Home  Forceps  Birth Center  Vacuum  Normal (face down)  Vaginal  Posterior occiput (face up)  Hours of labor:  Name of obstetrician/midwife:  Mutrition: (please check all past & present and list the age/ length of time for each)  Past: Present:  Breast  Breast  Brownia Intervention:  Medical Intervention:  Medical Intervention:	Mother's Name:		Father's Na	her's Name:			
City, State, Zip Code:  Home Phone:  Who referred you to our office?  How else did you hear about us?  Date of birth:  Gender:  Child's Social Security Number (if known):  Birth Length:  Current Weight:  Current Length/Height:  Current Length/Height:  Birth History: (please check all that apply)  Home  Forceps  Birth Center  Vacuum  Normal (face down)  Vaginal  Posterior occiput (face up)  Posterior occiput (face up)  Hours of labor:  Name of obstetrician/midwife:  Mutrition: (please check all past & present and list the age/ length of time for each)  Past: Present:  Breast  Breast  Brownel  Brownel  Breast  Brownel  Brownel  Breast  Brownel  Breast  Brownel  Breast  Brownel  Breast  Brownel  Brownel  Breast  Brownel  Brownel  Breast  Brownel  Brownel  Breast  Breast  Brownel  Breast  Breast  Brownel  Breast  Brownel  Breast  Breast  Brownel  Breast  Breast  Brownel  Breast  Breast  Brownel  Breast  B	Address:						
Date of birth:  Gender:	City, State, Zip Code:						
Date of birth:  Gender:	Home Phone:	Email	I Address: _				
Date of birth:	Who referred you to our offi	itus?					
Gender:	now else did you near abou	ıt us:					
Gender:	Date of birth:						
Child's Social Security Number (if known):    Parent's Social Security Number (just one):   Current Weight:	Gender:		Birth \	Birth Weight:			
Birth History: (please check all that apply)  Home	Child's Social Security Num	iber (if known):	Birth I	Birth Length:			
Birth History: (please check all that apply)  Home	Parent's Social Security Nu	mber (just one):	Curre	nt Weight:			
Home			Curre	nt Length/Height:			
Home	Pirth History (places show	ok all that apply)					
Birth Center	;;			□ Enidural Anaethasia			
□ Hospital □ Normal (face down) □ Oral Pain Drugs □ Vaginal □ Posterior occiput (face up) □ Pitocin □ Cesarean □ Breech □ Other drug/intervention: □ □ □ Hours of labor: □ □ Name of obstetrician/midwife: □ □ Nutrition: (please check all past & present and list the age/ length of time for each)  Past: Present: Age/ Length of time: □ □ Breast □ □ Bottle (breast milk) □ □ Formula □ □ Solid Foods □ ■ Medical Intervention:				•			
□ Vaginal □ Posterior occiput (face up) □ Pitocin □ Cesarean □ Breech □ Other drug/intervention: □    Hours of labor: □   Name of obstetrician/midwife: □    Nutrition: (please check all past & present and list the age/ length of time for each)  Past: Present: Age/ Length of time: □ □ Breast □ □ Bottle (breast milk) □ □ Formula □ □ □ Solid Foods □    Medical Intervention:			m)				
Cesarean							
Hours of labor:			(1400 4Þ)				
Name of obstetrician/midwife:  Nutrition: (please check all past & present and list the age/ length of time for each)  Past: Present:  Breast  Bottle (breast milk)  Formula  Solid Foods  Medical Intervention:	_ 000a.0a	_ <b>_</b>					
Nutrition: (please check all past & present and list the age/ length of time for each)  Past: Present: Age/ Length of time:  Breast Breast Bottle (breast milk) Formula Solid Foods  Medical Intervention:	Hours of labor:	<del>-</del>					
Past: Present: Age/ Length of time:  Breast Bottle (breast milk) Solid Foods Solid Foods Solid Intervention:	Name of obstetrician/midwi	te:					
Breast	Nutrition: (please check all	l past & present and	d list the age	e/ length of time for each)			
Breast	Past: Present:	Age/ Len	ngth of time:	,			
□ □ Formula □ □ Solid Foods  Medical Intervention:							
□ □ Formula □ □ Solid Foods  Medical Intervention:	□ □ Bottle (brea	st milk)					
□ □ Solid Foods	<ul><li>Formula</li></ul>						
	□ □ Solid Foods	)					
	Medical Intervention:						
Vaccination History (please check all that apply):							
The second secon	Vaccination History (please	check all that apply	<i>(</i> ):				
(1) (2) (3) (1) (2) (3) (4)							
□ □ MMR □ □ □ □ Haemophilus Influenzae Type B (Hib)							
DTaP Pneumococcus							
□ □ Polio □ □ Chicken Pox							
□ □ □ Hepatitis B □ Influenza (number of times:) □ □ □ Pediarix (DTP/Polio/Hep B)		TD/Dalia/Han D\		influenza (number of times:)			



		riptions of antibiotics has your child taken in the last 6 months? otics in his/her lifetime? ther prescription medications your child has taken in the last year:
Name of p	ediatri	cian:
		f you child has had any of the following symptoms or diagnoses in the past year and any treatment they received for it.
Past year:	Lifetime:	Treatment:
		Ear Infections
		Chronic colds/cough
		Recurrent Fevers
		Asthma
		Allergies
		Colic
		Stomach/digestive problems
_		Constipation
		Diarrhea
		Bed Wetting Seizures
П		Rashes
		Scoliosis
_		ADHD
		ADHDLearning Disorder
		Temper Tantrums
		Sleeping Problems
		Headaches
		Autism
		Other (please explain):
Chiroprac		
What is yo	our prin	nary concern for your child's health?
Any secor	ndary c	oncerns?
Anything 6	else yo	u would like the doctor to know about your child?
to the bod your child other heal	ly and t 's body Ith cons	practic remove interference to the transmission of nerve messages from the brain the body to the brain, by giving a chiropractic adjustment to the spine. This allows to heal with its maximum potential. Although this is our first priority, there are siderations that we would be glad to discuss with you and/or provide resources for re information. Please circle the topics you would like to learn more about for your
Medication Authorization	n for car	Physical Activity Sleep Stress Environmental Toxins Vaccinations Other (please list):  e of a minor: I hereby authorize this office and its Doctors to administer care as they so deem
necessary to	my son	/daughter/ward (upon approval of parent/guardian).
Parent's sign	nature: _	Date: