PN#:_______________________

Pediatric History Form

PATIENT DEMOGRAPHICS

Today's Date
_____/_____/____

Childs Name_____________________________Date of Birth _____/_____/______ Age: ____

Birth Height: _______ Birth Weight: _______ Current Height: ______ Current Weight: _____

Mailing
Address:____

City _______________ State _____ Zip __________ Phone (Home) ____________________

Mother's Name: ____________________ DOB____/____/____ Mother's Mobile ___________

Father's Name: _____________________ DOB ____/____/____ Father's Mobile___________

Pediatrician/Family MD _____________________________City/State ___________________

Last Visit: ____/____/____

Reason for visit:____

Who is responsible for this bill?
____

DR. Signature___________________________________

PN#:______________________

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain:

____

If your child is experiencing ***Pain/Discomfort please identify where and for how long***

____

____

1. **When did the** Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**? ___ No ___Yes If yes, when?

____

3. Any **bowel or bladder** problems since this problem began?: If yes, describe:

____

4. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

____

5. How long ago? _____Days _____Weeks ______Months _____Years
6. What were the results of past treatment?

____

7. How is this problem **NOW?:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Gradually Worsening ☐ On & Off

8. Please list any **medication taken** for this problem:

____

9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

____

____

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

____

____

DR. Signature___________________________________

PN#:_______________________

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders
☐ Behavioral Problems	☐ ADD/ADHD	☐ Growing Pains
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite
☐ Fainting	☐ Arm Problems	☐ Stomach Aches
☐ Ruptures/Hernia	☐ Fall down stairs	☐ Walking Trouble
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux
☐ Muscle Pain	☐ Sleeping Problems	☐ Asthma
☐ Heart Trouble	☐ Joint Problems	☐ Constipation
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension
☐ Scoliosis	☐ Anemia	☐ Colds/Flu
☐ Bed Wetting	☐ Colic	☐ Broken Bones
☐ Fall off swing	☐ Fall off skateboard/skates	☐ Allergies
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide
☐ Fall from changing table	☐ Fall off monkey bars	

to____

☐ Other:

____

Please list any and all prescription medications that your child is presently using and has used on more than one occasion.

# of Doses of ***antibiotics*** your child has taken:

____

____

____

____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

____

____

DR. Signature_________________________________

PN#:________________________

FEEDING HISTORY

Breast Fed: Y/N How long? ____________

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

Introduced to: Solid Foods @____________months Cow's milk @____________months

Allergies or intolerances: Y/N List:

____

PRENATAL HISTORY

Name of Obstetrician/ Midwife:

____

Weeks Pregnant at the time of Delivery

____

Complications during pregnancy/ delivery? Y/N

Explain:____

____

Induced into Labor ? Y/N Epidural? Y/N

Ultrasounds during pregnancy? Y/N

How many?__________

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

Cigarette/ Alcohol use during pregnancy? Y/N

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

If Caesarian Section, was it: ______Emergency or ______ Planned (check one)

Genetic disorders/ disabilities? Y/N List:

____

Birth Weight: _____________________ Birth Length: ___________________

APGAR Scores: _______-_______

Fully Vaccinated: Y/ N Any Reactions to Vaccines? Y/N
Explain________________________________

DR. Signature_____________________________________

PN#:______________________

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
___________ Sit up ___________ Respond to visual stimuli ____________Hold head up
____________ Walk alone

I understand that I am directly and fully responsible to Polaris Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

□ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

____

Parent or Legal Guardian's Signature Date

____

Doctor's Signature Date

DR. Signature____________________________________