ACHIEVE WELLNESS

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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	☐Allergies	☐Diarrhea	☐Broken bones
☐ADHD	☐Runny Nose	☐Poor Appetite	☐Sprains/Strains
☐Backaches	☐Itchy Eyes	☐Hyperactivity	☐Hernias
☐Heart Condition	☐Rashes	☐Behavioral	☐Neck Pain
☐Chronic Earaches	☐Unusual Moles	☐Poor Memory	☐Arm/Elbow Pain
☐Diabetes	☐Neuritis	☐Insomnia	☐Leg/Hip Pain
☐Tuberculosis	☐Digestive	☐Nightmares	☐Knee/Foot Pain
☐Hypertension	☐Sinus Trouble	☐Bed Wetting	☐Growing pains
☐Fever/Chills	☐Cough/Wheeze	☐Pain Urinating	☐Joint Pain
☐Frequent Colds	☐Chest Pain	☐Convulsions	☐Scoliosis
☐Arthritis	☐Constipation	☐Paralysis	☐Blood disorders
☐Headaches	☐Anemia	☐Muscle Pain	☐Stomach Aches
☐Asthma	☐Rheumatic Fever	☐Fainting	☐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 _____

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