



**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:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rashes | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Unusual Moles | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Arm/Elbow Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Leg/Hip Pain |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Digestive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Knee/Foot Pain |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> 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: Home Birthing Center Hospital Stepchild Adopted

Complications during pregnancy: Y/N List: _____

Cigarette / Alcohol use during pregnancy: Y/N

Birth intervention: Forceps Vacuum 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 _____

