



Confidential Pediatric History Form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you!
Thank You!

Date: _____ Referred By: _____

Child's Name: _____ Phone Number: _____

Do you have other immediate household family members who are patients here? Y N

If yes, please list them _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Weight: _____ Height: _____ Birth Date: _____

Name of Parents/Guardians: _____ Phone Number: _____

Purpose for Contacting Us? _____

Other Doctors seen for this condition: Y N If yes, please list doctor's name and prior treatments: _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | |
|--|--|--|--|
| <input type="radio"/> Ear infections | <input type="radio"/> Digestive problems | <input type="radio"/> Auto Accident | <input type="radio"/> Headaches |
| <input type="radio"/> Asthma/Allergies | <input type="radio"/> Bed Wetting | <input type="radio"/> Chronic Colds | <input type="radio"/> Growing/Back pains |
| <input type="radio"/> Colic | <input type="radio"/> Seizures | <input type="radio"/> Recurring Fevers | <input type="radio"/> Other: _____ |
| <input type="radio"/> Scoliosis | <input type="radio"/> ADHD | <input type="radio"/> Temper Tantrums | _____ |

Family History: _____

Previous Chiropractor: _____ Date of Last Visit: _____ Reason: _____

Were you satisfied? Y N Why? _____

Previous / Current Pediatrician: _____ Date of Last Visit: _____ Reason: _____

Number of doses of antibiotics your child has taken:

a) During the past six months: _____

b) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:

c) During the past six months: _____

d) Total during his/her life: _____

Vaccination History: _____

Feeding History

Breast Fed: Y N If yes, how long? _____ Formula: Y N If yes, how long: _____

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances: Y N If Yes, Please List:

If Yes, please list: _____ Other allergies or tolerances: Y N If Yes, please list: _____

Number of Hours Sleeping per Night: _____ Quality of Sleep: Good Fair Poor

Prenatal History:

Name of obstetrician/midwife: _____ Pediatrician / Family MD:

_____ Birth intervention: Forceps _____ Vacuum Extraction: _____ Caesarian Section: _____

Emergency or Planned?: _____ Ultrasounds during pregnancy? Y N If yes, how many: _____

Medications during pregnancy/delivery? Y N If Yes, please list them: _____

Cigarette/alcohol use during pregnancy? Y N How much and how often? _____

Childhood Diseases:

Chicken Pox: Y N Age: _____ Rubeola: Y N Age: _____ Whooping Cough: Y N Age: _____

Rubella: Y N Age: _____ Other: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? Y N – If yes, please explain _____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y N If Yes, Please list: _____

Has your child ever been involved in a car accident? Y N If yes, please explain: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE BOTH YOU AND YOUR CHILD TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Dane Ericson, DC - Affiliate of The Wellness Way to administer care to my son/daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Please send completed form to info@drosmon.com

Signed: _____ Relationship to Patient: _____ Date: _____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and disease or entity.

Initials: _____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials: _____

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

Initials: _____

I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials: _____

I acknowledge that any insurance I may have is an agreement between the center and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials: _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Initials _____