413 King George Road, Suite 205 • Basking Ridge, NJ 07920 • Phone: 908.903.1901 • Fax: 908.903.1902

PEDIATRIC HISTORY FORM

Dear New Patient,

It is a 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 help us some you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: ______________________________ S.S.#: ______________________

Address: ______________________________ City: ______________________

State: ______________ Zip: ______________ Home Phone: ______________________

Birth Date: _____ / _____ / _____ Parents Cell Phone: ______________________

Sex: ________ Weight: ___________ Height: ___________ How did you find out about us: ______________

Names of Parents / Guardians: ____

Purpose For Contacting Us? ____

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: ___________

Other Health Problems? ____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other

Family History: ____

Previous Chiropractor: ____

Date of Last Visit: _____ / _____ / _____ Reason: ______________________________

Name of Pediatrician: ____

Date of Last Visit: _____ / _____ / _____ Reason: ______________________________

Number of Doses of <u>Antibiotics</u> Your Child has Taken: ______________________________

During the Past Six Months: ________ , Total During His / Her Lifetime: ______________________

Number of Doses of <u>Other Prescription Medications</u> Your Child has Taken: ______________________

During the Past Six Months: ________ , Total During His / Her Lifetime: ________ List: ______________

Vaccination History: ____

Any Adverse Reactions? _____ N _____ Y Please Explain: ______________________________

Prenatal History:

Name of Obstetrician / Midwife: ____

Complications During Pregnancy? _____ N _____ Y , List: ______________________________

Ultrasounds During Pregnancy? _____ N _____ Y , Number: ______________________________

Medications During Pregnancy / Delivery? _____ N _____ Y , List: ______________________

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

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Birth Intervention: ____ Forceps ____ Vacuum Extraction
____ Caesarian Section, Emergency or Planned (Circle)

Complications During Delivery? _____ N _____Y , List: ____________________

Genetic Disorders or Disabilities: _____ N _____Y , List: ____________________

Birth Weight: _______ Birth Length: _______ APGAR Scores: ____________________

Feeding History:

Breast Fed: _____ N _____Y , How Long: ____________________

Formula Fed: _____ N _____Y , How Long: _______ Type: ____________________

Introduced to Solids at: _____ Months , Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____Y , List: ____________________

Developmental History:
During the following times 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 Sound
_____ Respond to Visual
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

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, gown stairs, etc.). Was this the case with your child? _____ N _____Y

Is / has your child been involved in any high impact or contact type sports: (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ N _____Y , List: ____________________

Has Your Child Ever Been involved in a Car Accident? _____ N _____Y , List: ____________________

Has Your Child Been Seen on an Emergency Basis? _____ N _____Y , List: ____________________

Other Traumas Not Described Above? _____ N _____Y , List: ____________________

Prior surgery: _____ N _____Y , List: ____________________

Menarche: _____ N _____Y , Age: ____________________

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors 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.

Name of Insurance Company: ____________________ Policy #: ____________________

Signed: ____________________ Witnessed: ____________________ Date: _____ /_____ /_____