Vogt Family Chiropractic

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 help serve you better, please complete the following information. We look forward to working with you! Thank you!

Date: _____ Referred By: _____

Patient Name: _____ Phone Number: _____

Address: _____ City: _____State: _____Zip: _____

Birth Date: _____ Sex: _____ Weight: _____ Height: _____S.S.#: _____

Names of Parents/ Guardians: _____

Purpose for contacting us? _____

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

_____

Other health problems? _____

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

- ❑ Ear infections
- ❑ Asthma/ Allergies
- ❑ Colic
- ❑ Scoliosis
- ❑ Digestive problems
- ❑ Bed wetting
- ❑ Seizures
- ❑ ADHD
- ❑ Auto accident
- ❑ Chronic colds
- ❑ Recurring fevers
- ❑ Temper tantrums
- ❑ Headaches
- ❑ Other _____

Family History: _____

Previous chiropractor: _____ Date of last visit: _____Reason: _____

Were you satisfied: _____ Why? _____

Name of 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:

a) During the past six months:_____

b) 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. Cows' milk at _____months.

Prenatal History:

Complications during pregnancy? Y/N If yes, please list them: _____

Ultrasounds during pregnancy? Y/N Y If yes, how many: _____

Medications during pregnancy/ Delivery? Y/N If yes, please list them: _____

Cigarette/ alcohol use during pregnancy? Y/N

Location of birth: Hospital: _____ Home: _____ Other: _____

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

Complications during delivery? Y/N If yes, please list them: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Childhood diseases:

Chicken Pox: Y/N age: ___ Rubeola: Y/N age: ___ Whooping Cough: Y/N age: ___

Rubella: Y/N age: ___ Mumps: Y/N age: ___ Other: _____ Y/N age: ___

Developmental History:

. At what age was your child able to:

Respond to sound: _____ Cross Crawl: _____
Respond to visual stimuli: _____ Stand Alone: _____
Hold head up: _____ Walk Alone: _____
Sit up: _____

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

Has your child fallen from a high place? Y/N If yes, please list: _____

Prior surgery? Y/N If yes, please list: _____

I hereby authorize (Your Office) to administer care to my son/ daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Relationship to patient: _____

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