Pediatric History Form

Weiss Chiropractic, PLLC • 124 W Savidge St • Spring Lake, MI 49456 •
www.weisschirocenter.com

Date: ____________
Email:____
Name: _____________________________
Address: __________________________________
City, State, Zip: __________________________
Home Phone: ________________________
D.O.B.: ________ **Sex:** ________ **Weight:** ________ **Height:**________

Name of Parents/Guardians:
____
Referred By:
____
Purpose for Contacting us?
____
Other Doctors seen for this condition? No Yes (Name:
_______________________)
Other Health Conditions? ______________________
Circle 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: __________
Previous Chiropractor: __________________________
Date of Last Visit: ____/____/____
Reason:
____
Name of Pediatrician: ___________________________
Date of Last Visit: ____/____/____
Is it ok if we send him/her updates on your child's care?____________________
Number of doses of antibiotics your child has taken?
During the past 6 months: ______ , Total during his/her lifetime: ______
Number of other doses of other prescription medications:
During the past 6 months: ______ , Total during his/her lifetime: ______ List:
____
Vaccination History: Full schedule Partial/Delayed Schedule N/A

Prenatal History

Complications during pregnancy? No Yes
(____)
Ultrasounds during pregnancy? No Yes (______)
Medications during pregnancy/delivery? No
Yes(______________________________________)
Cigarette/Alcohol use during pregnancy? No Yes
Name of Obstetrician/Midwife: __________________ **Location of birth:** Home
Birthing Center Hospital
Birth Intervention(s): Forceps Vacuum Extraction Caesarian Section(emergency or planned?)
Complications during delivery? No Yes **Genetic disorders or disabilities?** No
Yes
Birth Weight: ________ **Birth Length:** _______ **APGAR Scores:** _______, _______

Feeding History

Breast fed: No Yes (How Long: ______)
Formula fed: No Yes (How Long:_______)
Introduced to **solids** at _______ months, **cow's milk** at _______ months, **grains** at ________months
Food/Juice Allergies or Intolerances:
No Yes (____)

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 Stimuli
______ 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, stairs, etc.)
Was this the case with your child? No Yes

Is/Has your child been involved in any high impact or contact sports (I.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, etc) ? No Yes
(____)
Has your child ever been involved in a car accident? No Yes
(______________________________)
Has your child been seen on an emergency basis? No Yes
(_______________________________)
Other Traumas not described above?
____

Prior Surgery: No Yes
(____)

We are here to serve you and encourage you to ask questions.

Your participation is vital and will help determine your results.

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 understand that no cures are promised (or implied) and results are not guaranteed. I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I now authorize Dr. Weiss to proceed with any necessary treatments for my son/daughter. I have read Dr. Weiss' office policies and consent to treat information, and I agree with them by signing below:

Signed: ____ Date: ______/______/______

Witnessed: ____________________________________ Date: ______/______/______