Thrive Chiropractic
Amplify Your Life

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Pediatric History Form

Dear Parent,

It is our pleasure to welcome you to our family of healthy and happy 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 and your family to build better health.

Patient Name_____ Birth Date

Weight: _____ Height:_____ Referred by

Names of Parents/ Guardians:

Purpose for Contacting Us?

Have You Seen Other Doctors for this condition? Y N Doctor's Name and Prior Treatment:

Other Health Problems?

✓ Check any of the following conditions your child has suffered from during the past 6 months

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

Name of Pediatrician:

Date of Last Visit_____ Reason for Visit

Are you satisfied with the care your child has received there? Y N Why?

Has your child been vaccinated: Y N Age of First Vaccination

Number of doses of Antibiotics your child has taken:

During the Last 6 Months _____ Total during their lifetime

Number of Prescription medications your child has taken

Durning the last 6 Months _____ Total during their lifetime

List of Medications:

Prenatal History:

Name of Obstetrician/ Midwife:

Complications during Pregnancy? Y N List:

Ultrasounds Durning Pregnancy? Y N If So, how many?

Medications during Pregnancy/Delivery? Y N List:

Cigarette/ Alcohol use during pregnancy: Y N

Location of Birth (Check One): Hospital_____ Birthing Center _____ Home

Birth Intervention:

Forceps_____ Vacuum Extraction_____Cesarean Section_____Emergency or Planned?

Was there any complication during delivery? If yes, please describe Y N

Genetic Disorders or Disabilities? Y N If Yes, please describe

Birth Weight_____Birth Length_____APGAR Score:

Feeding History:

Breast Fed: Y N How Long?

Formula Fed: Y N How long?_____ Type?

Introduced Solids at: _____ Months Cow's Milk Introduced at _____ Months

Food/ Juice Allergies or Intolerances: Y N If Yes, please describe

According to the National Safety Council, approximately 50% of all children fall head first from a high place during the first year of life. (I.e a bed, changing table, stairs, couch, etc.) Was that true for your child? Y N If yes, please describe

Is/ has your child ever been involved in any high impact or contact type sports (I.e Soccer, Football, Gymnastics, baseball, cheerleading, Martial Arts)? Y N If yes, which sport?

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

Has Your child ever been seen on an emergency basis Y N If yes, please describe.

Other Traumas not described above?

Prior Surgery? Y N If yes, please describe.