Pediatric History Form

Gulf Coast Rehabilitation and Wellness Center welcomes 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 serve you better, please complete the following. 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: ____ / ____ / ____ Work Phone: ______________

Sex: ______ Weight: ______ Height: ______ Referred By: ______________

Names of Parents / Guardians: ______________________________

Purpose for Contacting Us? ______________________________

Has the patients seen other Doctors for this condition?: YES NO

Doctor's Name and Prior Treatments: ______________________________

____

____

Does the patient have any other health problems? ______________________________

____

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

❑ Ear Infections	❑ Scoliosis	❑ Seizure	❑ 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: ______________________________

Are you satisfied with the care you child has received there? YES NO

Number of Doses of **Antibiotics** your child has taken:

During the past six months: ________ ,Total during his/her lifetime: ________

Number of Doses of **Other Prescription Medications** Your Child has Taken:

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

Vaccination History: ______________________________

Prenatal History:

Name of Obstetrician / Midwife: ______________________________

Complications during pregnancy? YES NO List: ______________________________

Ultrasounds during pregnancy? YES NO Number: ______

Medication during pregnancy/delivery? YES NO List: ______________________________

Cigarette/Alcohol use during pregnancy? YES NO

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home

Birth intervention: ❑ Forceps ❑ Vacuum Extraction ❑ Cesarian Section, (Emergency or Planned?)

Complications during delivery? YES NO List: ____________________

Genetic Disorders or disabilities? YES NO List: ____________________

Birth Weight: ________ Birth Length: ________ APGAR scores: ________ , ________

Feeding History:

Breast Fed? YES NO How Long?: ________

Formula Fed? YES NO How Long? ________ Type: ____________________

Introduced to solids at: ________ Months, Cows' Milk at ________ Months

Food/Juice allergies or Intolerances: YES NO 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 (sinal 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 the first year of life (i.e.: bed, changing table, down stairs, etc.). Was this the case with your child? YES NO

Is / has your child been involved in any high impact or contact type sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? YES NO List: ____________________

Has your chid ever been involved in a car accident? YES NO List: ____________________

Has your child been seen on an emergency basis? YES NO List: ____________________

Other traumas not described above? YES NO List: ____________________

Prior surgery? YES NO List: ____________________

Menarche? YES NO Age: ________

Childhood Diseases:

Chicken Pox ❑ Age: ________

Rubella ❑ Age: ________

Rubeola ❑ Age: ________

Mumps ❑ Age: ________

Whooping Cough ❑ Age: ________

Other ❑ Age: ________

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 clearly understand and agree that I am personally responsible for payment of all fees by this office.

Name of Insurance Company: ____________________ Policy #: ____________________

Signed: ____________________ Witnessed: ____________________ Date: ________