

Kim Family Chiropractic
Confidential 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: _____ Prov: _____ Postal Code: _____

Birth Date: _____ Sex: _____ Weight: _____ Height: _____ S.I.N#: _____

Names of Parents/ Guardians: _____

Purpose for contacting us? _____

Other doctors seen for this condition: N/Y 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:

- | | | | |
|--------------------------------------------|---------------------------------------------|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic colds | <input type="checkbox"/> Growing/ Back pains |
| <input type="checkbox"/> Scoliosis | | <input type="checkbox"/> Recurring fevers | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____ Date of last visit: _____ Reason: _____

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: N/Y If yes, how long? _____ Formula: N/Y If yes, how long? _____

Introduced to solids at __ months. Cows' milk at _____ months.

Food/ juice allergies or tolerances: N/Y If yes, please list: _____

Prenatal History:

Name of obstetrician/ midwife: _____

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

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

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

Cigarette/ alcohol use during pregnancy? N/Y

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

Birth intervention: Forceps: ___ Vacuum Extraction: ___ Caesarian Section: ___ Emergency or Planned?

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

Generic disorders or disabilities? N Y If yes, please list them: _____

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

Childhood diseases:

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

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

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: _____

Cross Crawl: _____

Respond to visual stimuli: _____

Stand Alone: _____

Hold head up: _____

Walk Alone: _____

Sit up: _____

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, down stairs, etc.). Was this the case with your child? N/Y

Is/ has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). N/Y If yes, please list: _____

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

Has your child been seen on an emergency basis? N/Y If yes, please list: _____

Other traumas not described above? N/Y If yes, please list: _____

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

Menarche: N/Y If yes, at what age? _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Kim Family Chiropractic 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.

Signed: _____ Relationship to patient: _____