Jaffrey Chiropractic – Pediatric New Patient Intake Form

Today's Date _____

Pediatric History Form

It is a 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 us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name:_____

Address:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Other Phone: _____

DOB: _____ Age: _____ Sex: _____ Height: _____ Weight: _____lbs. Name of parent(s)/guardian(s): _____Referred by: _____

Purpose for contacting us:_____

Other doctors seen for this condition:_____

Other health problems: _____

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

❑ Ear infections ❑ Asthma/Allergies ❑ Colic ❑ Bed Wetting ❑ Scoliosis ❑ Digestive Problems

❑ Seizures ❑ ADHD ❑ Chronic Colds ❑ Temper Tantrums ❑ Headaches ❑ Growing Pains

❑ Recurring Fevers ❑ Other_____

Previous Chiropractor:_____ Last Visit:____/____/____

Reason for last visit: _____

Who is your child's pediatrician? _____ Last Visit: ____/____/____

Reason for last visit:_____

List any medications, herbs, or over-the-counter remedies that your child has taken or is currently taking: (*please include how long each of these have been used)* _____

Number of Courses of Antibiotics your child has taken in the past 6 months: _____

Number of Courses of Antibiotics taken during his/her lifetime: _____

Has your child been vaccinated? ❑ Yes ❑ No If No, do you plan on vaccinating your child? ❑ Yes ❑ No

Did you notice any problems or changes after the vaccination? ❑ Yes ❑ No

If yes, please explain:_____

Prenatal History

Please list any complications during the pregnancy: _____

Did you smoke, drink, or use drugs during your pregnancy? _____

Where was your child born (hospital, home, etc.)? _____

Please check all of the interventions used during your child's birth:

❑ Forceps ❑ Vacuum Extraction ❑ C-Section ❑ Induced Labor ❑ Epidural ❑ Other_____

OVER

Please list any complications during delivery: _____

Birth weight: _____ Birth length: _____ APGAR score: _____

Was your child born with any genetic disorders/disabilities? _____

Feeding History:

Was your child breast- fed or bottle-fed (how long)? _____

When was your child introduced to solid food? _____

Are you aware of any food allergies? _____

Developmental History:

Would you consider your child to be developing at a "normal" rate? ❑ Yes ❑ No

If no, please explain:_____

According to the National Safety Council, 50% of children fall head-first. Has this happened to your knowledge? ❑ Yes ❑ No

Please list any sports that your child is/has been involved in (soccer, hockey, football, gymnastics, trampoline, cheerleading, diving, etc.): _____

Please list any car accidents, ER visits, surgeries, traumas, concussions, illnesses, etc. that your child has been through:

_____

Has your child had: ❑ Chicken Pox ❑ Measles ❑ German Measles ❑ Whooping Cough ❑ Other _____

Is There Anything Else You Feel We Should Know?_____

_____

I agree that I have answered the questions on this form truthfully to the best of my knowledge.

Parent's/Guardian's Signature_____ Date ____/____/____