

Ribley Family Chiropractic

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: _____ S.S. # _____ Birth Date: ____ / ____ / ____
 Male / Female (circle one) Weight: _____ lbs Height: _____ ft. ____ in. Phone #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Parent /Guardian: _____ Referred By: _____

Purpose for contacting our office? _____

Other Doctors seen for this condition? Y / N Doctor's names and prior treatments: _____

List other health problems: _____

Family history: _____

Check any of the following conditions that currently apply:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Growing/Back Pains | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Car Accident: when? _____ | |

Personal History

Previous Chiropractic Care? Y / N Last Visit: ____ / ____ / ____
 Name of Pediatrician: _____ Last Visit: ____ / ____ / ____ Reason: _____
 Are you satisfied with the care your child has received at the pediatrician? Y / N
 # of doses of antibiotics your child has taken: Past 6 months _____ Lifetime: _____
 # of doses of other prescription medications your child has taken:
 Past 6 months _____ Lifetime: _____ List: _____
 Vaccination History: _____

Prenatal History (circle what applies)

Name of Obstetrician / Midwife: _____
 Complications during pregnancy / delivery? Y / N Explain: _____
 Ultrasounds during pregnancy? Y / N How Many? _____
 Medications taken during pregnancy / delivery? Y / N List: _____
 Cigarette / Alcohol use during pregnancy? Y / N
 Location of birth (circle one): Hospital Birthing Center Home
 Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section
 If Caesarian Section, was it: _____ Emergency or _____ Planned
 Genetic disorders / disabilities? Y / N List: _____
 Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ - _____

Feeding History

Breast Fed: Y / N How long? _____ Does the Baby prefer one side or the other? Y / N
 Formula Fed: Y / N How long? _____ Type: _____
 Introduced to: Solid foods @ _____ months Cow's milk @ _____ months
 Food / Juice allergies or intolerances: Y / N List: _____

Child's Name: _____

Date: _____

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

_____ Respond to stimuli

_____ Cross crawl

_____ Stand alone

_____ Respond to visual stimuli

_____ 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, stairs, chair).

Did your child have a fall similar to what was described above? Y / N Explain: _____

Is/Has your child been involved in any high impact or contact sports? Y / N List: _____

Has your child been seen by a physician on an emergency basis? Y / N Explain: _____

Other Traumas/Surgery not described above? Y / N Explain: _____

Childhood Diseases:

Chicken Pox Y / N, Age: _____

Mumps Y / N, Age: _____

Rubella Y / N, Age: _____

Whooping Cough Y / N, Age: _____

Rubeola Y / N, Age: _____

Other _____ Y / N, Age: _____

Lifestyle (please check what applies)

Does your child: _____ Eat health food products (organic products)

_____ Drink water

_____ Take vitamins Type: _____

_____ Take probiotics

Exercise: _____ none _____ moderate _____ daily

_____ heavy

Hobbies/interest: _____

Notes: _____

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 child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/guardian name (please print): _____

Parent/guardian signature: _____

Date: _____