



Spencer Family CHIROPRACTIC

Pediatric History Form

Date _____ Referred _____
By _____
Patient Name _____ Phone _____
Number _____
Address _____

Town _____ State _____ Zip _____

Birth Date _____ Sex _____ Weight _____ Height _____
SS# _____ - _____ - _____

Names of
Parents/Guardians _____

Purpose for contacting
us _____

Other doctors seen for this
condition _____

Treatment _____

Check any of the following that pertains to your child:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures | <input type="checkbox"/> sustained a fall | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Traumatic Birth | <input type="checkbox"/> |
| <input type="checkbox"/> Scoliosis | | | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Adverse vaccination reaction | |
| <input type="checkbox"/> | | | |

Other _____

Family History _____

Name of Pediatrician

Date of your last visit _____
Reason _____ Treatment _____

Number of doses of antibiotics your child has taken:

In the last 6 months _____ Total during his/her life _____

Number of doses of other prescription medications your child has taken:

In the last 6 months _____ Total during his/her life _____

Vaccination history:

Feeding History:

Breast Fed- If yes, how long? _____ Formula- If yes, how long? _____

Introduced solids at _____ months. Cow's milk at _____ months.

Prenatal History:

Complications during pregnancy? Explain _____

Ultrasounds during pregnancy? How many? _____

Medications during pregnancy/delivery? Please list _____

Cigarette, alcohol, drug use during pregnancy? Frequency _____

Location of birth Home Birthing facility Hospital

Other _____

Birth /Delivery complications? Forceps Vacuum Extraction Cesarean Section

Other _____

Birth Weight _____ Birth Length _____ Apgar Scores _____

Childhood diseases:

Chicken Pox Age: _____ Rubeola Age: _____

Rubella Age: _____

Pertussis (Whooping Cough) Mumps Age: _____
Other _____

Developmental History:

At what age was your child able to?

Respond to sound _____ Crawl _____
Respond to visual stimuli _____ Stand _____
Alone _____
Hold head up _____ Walk _____
Alone _____
Sit _____

Has your child ever been involved in a car accident? No Yes (list)

Has your child ever fallen? No Yes (list)

Prior Surgery? No Yes (list)

I hereby authorize Spencer Family Chiropractic to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed _____ Date _____

Relationship to
patient _____
