

# PEDIATRIC HISTORY FORM

Office Use Only  
SEI1 \_\_\_ SEI2 \_\_\_ JDB \_\_\_

PATIENT NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SSN: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_ AGE: \_\_\_\_\_  MALE  FEMALE

NAME OF PARENTS/GUARDIANS: \_\_\_\_\_

## HOW DID YOU FIRST HEAR OF ISDALE CHIROPRACTIC?

PARENT IS A PATIENT  TV  NEWSPAPER  BILLBOARD  FRIEND  OTHER: \_\_\_\_\_

WHO CAN WE THANK FOR REFERRING YOU TO US: \_\_\_\_\_

PURPOSE FOR CONTACTING US? \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS CONDITION?  YES  NO IF YES, PLEASE LIST DOCTORS AND TREATMENTS:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## HEALTH HISTORY:

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM DURING THE LAST 6 MONTHS:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> EAR INFECTIONS     | <input type="checkbox"/> SEIZURES         | <input type="checkbox"/> GROWING PAINS |
| <input type="checkbox"/> ASTHMA/ALLERGIES   | <input type="checkbox"/> ADHD             | <input type="checkbox"/> NECK PAIN     |
| <input type="checkbox"/> COLIC              | <input type="checkbox"/> CAR ACCIDENT     | <input type="checkbox"/> BACK PAIN     |
| <input type="checkbox"/> SCOLIOSIS          | <input type="checkbox"/> CHRONIC COLDS    | <input type="checkbox"/> SLEEPLESSNESS |
| <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> RECURRING FEVERS | <input type="checkbox"/> OTHER: _____  |
| <input type="checkbox"/> BED WETTING        | <input type="checkbox"/> HEADACHES        |  |

HAS YOUR CHILD EVER BEEN HOSPITALIZED?  YES  NO IF YES, WHY? \_\_\_\_\_

HAS YOUR CHILD HAD ANY SIGNIFICANT INJURIES? \_\_\_\_\_

IS YOUR CHILD ON ANY MEDICATIONS? \_\_\_\_\_

HAS YOUR CHILD TAKEN ANY ANTIBIOTICS?  NO  YES;

IF YES, HOW MANY DOSES IN THE LAST 6 MO? \_\_\_\_\_ TOTAL DURING HIS/HER LIFETIME: \_\_\_\_\_

HAS YOUR CHILD BEEN VACCINATED?  NO  YES; WHEN: \_\_\_\_\_

ANY CHILDHOOD DISEASES?

- |                                      |   |                                       |
|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> WHOOPING COUGH | <input type="checkbox"/> RSV          |
| <input type="checkbox"/> RUBELLA     | <input type="checkbox"/> MUMPS          | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> MEASLES     | <input type="checkbox"/> PERTUSSIS      |                                       |

NAME OF PEDIATRICIAN: \_\_\_\_\_

## PRENATAL HISTORY:

MOM'S HEALTH DURING PREGNANCY: \_\_\_\_\_

COMPLICATIONS DURING PREGNANCY:  NO  YES ; PLEASE LIST: \_\_\_\_\_

MEDICATIONS DURING DELIVERY: INDUCTION  YES  NO EPIDURAL  YES  NO OTHER: \_\_\_\_\_

BIRTH INTERVENTION:  FORCEPS  VACUUM EXTRACTION  CAESARIAN – EMERGENCY / PLANNED?

COMPLICATIONS DURING DELIVERY:  NO  YES ; PLEASE LIST: \_\_\_\_\_

DELIVERY:  < 36 WEEKS  37 – 42 WEEKS  > 42 WEEKS

BIRTH WEIGHT: \_\_\_\_\_ LENGTH \_\_\_\_\_

## FEEDING HISTORY:

BREAST FED:  YES  NO ; HOW LONG? \_\_\_\_\_

FORMULA FED:  YES  NO ; HOW LONG? \_\_\_\_\_

INTRODUCED TO SOLIDS AT: \_\_\_\_\_ MONTHS; COW'S MILK AT \_\_\_\_\_ MONTHS

FOOD / JUICE ALLERGIES OR INTOLERANCES  NO  YES; PLEASE LIST: \_\_\_\_\_

**DAILY ACTIVITIES/SPORTS**

IS YOUR CHILD INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS? (I.E. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC) \_\_\_\_\_

PLEASE LIST ANY INJURIES AS A RESULT OF THEIR ACTIVITIES: \_\_\_\_\_  
\_\_\_\_\_

**REGARDING SYMPTOMS:**

IS IT RELATED TO AN AUTOMOBILE ACCIDENT?  NO  YES

WHEN DID THE SYMPTOMS FIRST START? \_\_\_\_\_

HOW FREQUENT IS THE PAIN? \_\_\_\_\_

HOW DID THIS HAPPEN? \_\_\_\_\_

DESCRIBE THE PAIN: \_\_\_\_\_

WHAT MAKES IT WORSE? \_\_\_\_\_

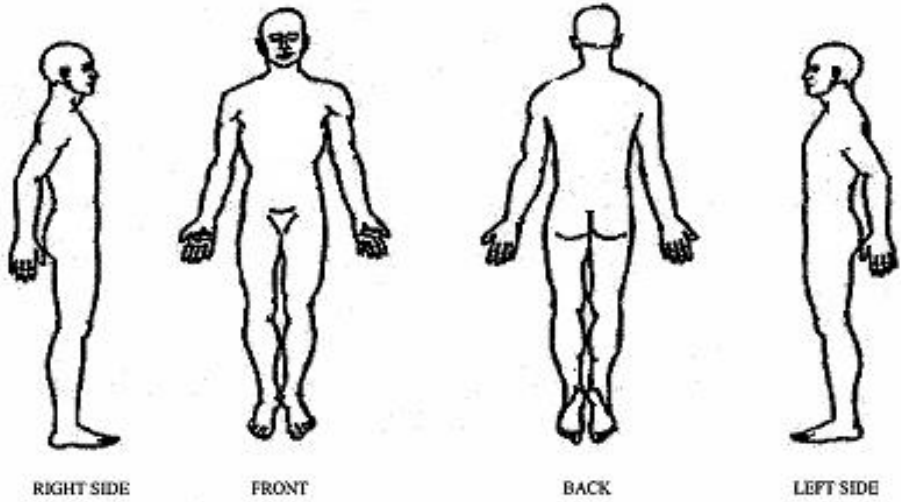
WHAT MAKES IT BETTER? \_\_\_\_\_

DOES IT RADIATE TO ANY OTHER PARTS OF YOUR BODY? \_\_\_\_\_

HAS THIS CHANGED ACTIVITIES AT HOME? \_\_\_\_\_

Please mark the areas of all of your complaints on the diagrams to the right.

- N** = numbness
- T** = tingling
- P** = pain
- W** = weakness



PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_