SCHMITZ CHIROPRACTIC
Family Wellness Center

PEDIATRIC HEALTH HISTORY

Patient's Name:_____
Has your child been to a Chiropractor before? YES NO
Purpose for contacting us?_____
Have you been to other health care providers? YES NO
Doctor's names and prior treatments:_____
_____
Does your child have any other health problems?_____
_____
Please circle any of the conditions your child has suffered from during the past six months:

Ear infections	Scoliosis	Seizures	Chronic colds	Headaches
Asthma/Allergies	Digestive problems	ADHD	Colic	Back Pain
Car Accident	Recurring Fevers	Bed Wetting	Temper Tantrum	Other

Family History of illness:_____
_____

Name of Pediatrician_____
Phone:_____Date of last visit_____
Reason for last visit_____
Are you satisfied with the care you received there? YES NO
Antibiotics your child has taken: _____
During the past six months_____Total during his/her lifetime_____
Other medications your child has taken (including non-prescription):
_____
During the past six months_____Total during his/her lifetime_____
Vaccination History:_____

Has your child ever been involved in a car accident? YES NO
If yes, when?_____
Has your child ever been seen on an emergency basis? YES NO
If yes, when and what for?_____

Other traumas not described above?_____
Any surgeries?_____

Prenatal History:
Name of Obstetrician/Midwife_____
Any complications during pregnancy?_____
How many ultrasounds during your pregnancy?_____

Medications during pregnancy and/or delivery_____
Cigarette/Alcohol use during pregnancy? YES NO
Location of birth_____
Birth intervention: Forceps _____Vacuum extraction_____
C-Section_____ (emergency or planned)
Any complications during delivery?_____
_____
Genetic Disorders or Disabilities?_____
Birth Weight_____Length_____APGAR Score_____

Feeding History:
Are/did you breastfeed? YES NO If yes, for how long?_____
Are you formula feeding or supplementing with formula? YES NO
At what age was your child introduced to solids?_____
At what age was your child introduced to cow's milk?_____
Any food or juice allergies?_____

Developmental History:
During the following times your child's spine is the most vulnerable to stress, and should be routinely checked by a Chiropractor for prevention, and early detection, of vertebral subluxations (spinal nerve interference). At what age was your child able to:

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

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, down stairs, etc.). Was this the case with your child? YES NO

Is/has your child ever been involved in any high impact or contact sports? (Soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)
_____
_____

Childhood diseases:

Chicken Pox	Y/N, Age_____	Mumps	Y/N, Age_____
Rubella	Y/N, Age_____	Rubeola	Y/N, Age_____
Whooping cough	Y/N, Age_____	Other	Y/N, Age_____

Authorization to Treat a Minor

I hereby authorize treatment of my son/daughter as deemed necessary by Schmitz Chiropractic.

SIGNATURE:_____DATE:_____