Lifetime Health & Wellness

Confidential Pediatric History Form *(Please print clearly and fill in completely.)*

Date:_____ Referred by:_____

Patient's Name:_____ Birth Date:_____

Address:_____

Sex: ☐ Male ☐ Female Weight:_____ Height:_____ S.S.#:_____

Siblings and ages:_____

Name of Parents/Guardians:_____

Phone: home (____)_____ cell (____)_____ work (____)_____

Purpose for contacting us:_____

Other doctors seen for this condition: ☐ No ☐ Yes If yes, list doctor's name and prior treatments:_____

_____

Other health problems:_____

Check any of the following conditions your child has suffered from.

☐ Ear Infections	☐ Colic	☐ Scoliosis	☐ Auto Accidents
☐ Asthma/Allergies	☐ Digestive Problems	☐ Headaches	☐ Growing Pains
☐ Chronic colds	☐ Bed Wetting	☐ ADD or ADHD	☐ Back Pains
☐ Recurring fevers	☐ Temper Tantrums	☐ Seizures	☐ Anxiety Problems

☐ Other: _____

Previous chiropractor:_____ Date of last visit:_____

Reason for visit:_____

Name of pediatrician:_____ Date of last visit:_____

Reason for visit:_____

Medications your child regularly takes (prescription and over-the-counter): _____

_____

Number of doses of antibiotics your child has taken:

During past six months:_____ During his/her life:_____

Vaccination history:_____

Childhood diseases – If your child has had the following disease, please fill in age at time of occurrence:

Chicken Pox: _____ Rubeola: _____ Whooping Cough: _____

Rubella: _____ Mumps: _____ Other: _____

Prenatal History: *Experts around the world agree: the birth process, as we know it, may cause neurological trauma and damage to the infant.*

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Did you have an ultrasound during this pregnancy? ☐ Yes ☐ No If yes, Frequency_____

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital Type: ☐ Midwife ☐ OB-GYN ☐ Other

Was labor induced? ☐ Yes ☐No If yes, why? _____

Birth intervention: ☐ Doctor assisted ☐ Twisting ☐ Pulling ☐ Forceps ☐ Vacuum Extraction

☐ Caesarian Section - C-section was ☐ Emergency ☐ Planned

Genetic disorders or disabilities? Please explain_____

Feeding History:

Breast Fed: ☐ Yes ☐ No If yes, how long? _____ Formula: ☐ Yes ☐ No If yes, how long? _____

Introduced to solids at _____ months. Introduced to cow's milk at _____ months.

Food allergies or intolerances: _____

Developmental History: *What age did your child…*

Respond to sound_____ Respond to visual stimuli_____ Hold head up_____

Sit up _____ Crawl_____ Stand alone_____ Walk alone_____

Accident History: *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, down the stairs, etc.)*

Has your child ever taken a bad fall? If yes, explain_____

Has your child ever been involved in a car accident? If yes, explain_____

Has your child ever been seen at an emergency room: If yes, explain_____

Has your child ever participated in high impact or contact sports? If yes, explain_____

Other traumas not described above? If yes, explain_____

Prior surgery? No / Yes – If yes, what for? _____

Is there anything else you would like us to know about your child? _____

_____

Insurance:

Insured's Name: _____ Relationship:_____

Insured's S.S.#: _____ Insured's Date of Birth: _____

Name of Insurance Company: _____

Insurance I.D. #:_____ Insurance Group #: _____

Signature:

I hereby authorize Lifetime Health and Wellness to administer care to my son/daughter. To the best of my knowledge the information I have provided is correct.

Signed:_____ ***Relationship to patient:***_____