



WOLLEN
FAMILY CHIROPRACTIC
A PROACTIVE APPROACH TO LIFE

Date: _____
Pt #: _____

Pediatric History Form

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

Child's Name: _____ Mother's Name: _____

Social Security #: _____ Father's Name: _____

Address: _____

Phone #: _____ Birth date: _____ Age: _____ Current Weight: _____

Reason for This Appointment: _____

Other Doctors Seen for this Condition: _____

Other Health Problems that may not seem related to this issue but are present: _____

Previous Chiropractor: _____
NAME LOCATION

Circle Any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- | | | | | |
|--------------------|--------------------|---------------|------------------|--------------------|
| Ear Infections | Scoliosis | Seizures | Chronic Colds | Headaches |
| Asthma / Allergies | Digestive Problems | ADHD | Recurring Fevers | Growing/Back Pains |
| Colic | Bed Wetting | Car Accidents | Temper Tantrums | Other: _____ |

Pediatrician/Family MD: _____
NAME LOCATION

Date of Last Visit: _____ Reason for Visit: _____

Are You Satisfied with the Care Your Child has Received there? ____

Number of Doses of Antibiotics Your Child has Taken:
During the Last Six Months: _____ Total During His / Her Lifetime: _____

Number of Doses of Other Medications Your Child has Taken:
During the Last Six Months: _____ Total During His / Her Lifetime: _____

Immunization History: _____

PRENATAL HISTORY:

Type of Birth: Normal Vaginal Forceps Breech Cesarean Vacuum
Home Birthing Center Hospital Apgar Scores: _____

Birth Weight: _____ Birth Length: _____

Was there either of the following present at birth? : Jaundice Cyanosis

Complications During Pregnancy? _____

Length of Labor: _____ Complications: _____

Congenital Anomalies/ Defects: _____

Infant Feeding: Breast Until What Age? _____ Reason for Stopping? _____
Bottle Formula How Long: _____ Type: _____

Introduced to Solids at: _____ Months of Age, Cow's Milk at _____ Months.

Food/Juice Allergies or Intolerances: Y / N List: _____

Number of Hours of Sleep per Night: _____ Per Day: _____ Quality of Sleep: _____

Medications During Pregnancy / Delivery: _____

Cigarette / Alcohol use During Pregnancy: Y / N Amount: _____

Obstetrician/Midwife: _____
NAME LOCATION

DEVELOPMENTAL HISTORY:

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

_____ Respond to Sound	_____ Cross Crawl	_____ Sit Up
_____ Respond to Visual Stimuli	_____ Stand Alone	_____ Walk Alone
_____ Hold Head 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, downstairs, etc.). Was this the case with your child? Y / N

Is / Has your child been involved in any high impact or contact type sports (i.e. Soccer Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Y / N Type: _____

Has you Child ever been Involved in a Car Accident? Y / N List: _____

Other Traumas not Described Above? _____

Prior Surgery? _____ Age of Menarche: _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.
THANK YOU FOR MAKING WOLLEN FAMILY CHIROPRACTIC PART OF YOUR FAMILY'S
HEALTH CARE PLAN.**