

NATURALLY CHIROPRACTIC

Dr. Nylsa A. Correa

PEDIATRIC HEALTH HISTORY FORM

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State & zip code: _____ Home Phone: _____

Birth Date: _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Name of Guardians: _____

How did you hear from our office? --website --phone book -- money mailer --newspaper --referred by _____ -- Other _____

Is your family military or retired military? _____

Are you OK with us writing your child's name in our WELCOME BOARD? YES NO

Purpose for visiting our office? _____

Other Doctors seen for this situation? NO YES, Doctors names and treatment: _____

Check any of the following conditions your child has suffered from during the last 6 months:

Ear Infection	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma / Allergies	Digestive problems	ADHD / ADD	Recurring Fevers	Growing / Back Pain
Colic	Bed Wetting	Car Accident	Temper Tantrums	Other:

Family History: _____

Previous Chiropractor: _____ Date last visit: _____

Pediatrician: _____ Date last visit: _____

Reason: _____

Are you satisfied with the care your child received there? _____

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total during lifetime: _____

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

During the past 6 months: _____ Total during lifetime: _____

List them: _____

Vaccination history: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complication during pregnancy? NO YES, List: _____

Ultrasounds during pregnancy? NO YES, Number: _____

Medication during pregnancy? NO YES, List: _____

Cigarette or alcohol during pregnancy? NO YES

Name of patient: _____

Birth intervention: ___ Forceps ___ Vacuum Extraction ___ Cesarean Section, Emergency or Planned

Complications during delivery? NO YES, List: _____

Genetic Disorders or Disabilities? NO YES, List: _____

Birth weight: _____ Birth length: _____ Apgar Scores: _____

Feeding History:

Breast Fed: YES NO, How long? _____

Formula Fed: YES NO, How long? _____, Type: _____

Introduced to solids at _____ months, Cow's milk at _____ months

Food / Juice allergies or intolerance: YES NO, List: _____

Developmental History:

At what age was your child able to?

_____ Respond to sound _____ Cross crawl _____ Stand-alone

_____ Respond to Visual stimuli _____ Hold head up _____ Sit up _____ 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 (i.e. bed, changing table, downstairs, etc). Was this the case with your child? NO YES

Is / has your child been involved in any high impact or contact type sport (i.e. Soccer, gymnastics, football, etc)? NO YES

List: _____

Has your child ever been involved in a car accident? NO YES, List: _____

Has your child been seen on an Emergency basis? NO YES, List: _____

Other traumas not described above: _____

Prior surgeries: NO YES, List: _____

Menarche: NO YES, Age: _____

Childhood Diseases:

Chicken pox NO / YES, Age: _____ Whooping Cough NO / YES, Age: _____

Rubella NO / YES, Age: _____ Mumps NO / YES, Age: _____

Rubeola NO / YES, Age: _____ Other NO / YES, Age: _____

DOCTOR'S NOTES: _____

Recommendations: _____

Patient accepted: YES NO Referred

I have reviewed the information contained on this form with the patient

Dr's signature _____ Date _____