

PEDIATRIC PATIENT HISTORY

Child's Name: _____ SS#: _____
Last First MI

DOB: _____ Grade In School: _____ Sex: _____ Home Phone: (____) _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Mother's Name: _____ Cell/Work Phone: _____ / _____
Last First

Father's Name: _____ Cell/Work Phone: _____ / _____
Last First

Referred By: _____ Purpose of this appointment: _____

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)

Did you experience any of the following during your pregnancy:

- | | |
|--|--|
| <input type="checkbox"/> Severe viral infection during the first trimester | <input type="checkbox"/> Alcohol consumption and/or drug use |
| <input type="checkbox"/> Breech position during pregnancy | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Accident or Infections | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Severe stress | <input type="checkbox"/> Uncontrolled Diabetes |
| <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Toxemia |

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- | | |
|--|---|
| <input type="checkbox"/> Hospital birth | <input type="checkbox"/> Home birth |
| <input type="checkbox"/> Birthing home | <input type="checkbox"/> The labor was induced |
| <input type="checkbox"/> Long and/or difficult labor | <input type="checkbox"/> The delivery was rapid |
| <input type="checkbox"/> Placenta previa | <input type="checkbox"/> Breech birth |
| <input type="checkbox"/> Forceps or suction cup used | <input type="checkbox"/> Cord around the neck |
| <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Emergency c-section |
| <input type="checkbox"/> Elective c-section | <input type="checkbox"/> The child was premature (2+ weeks) |
| <input type="checkbox"/> The child was a "blue baby" | |

Comments: _____

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Newborn History

Did the child experience any of the following as a newborn:

- | | |
|--|--|
| <input type="checkbox"/> Required resuscitation/oxygen | <input type="checkbox"/> Distorted skull |
| <input type="checkbox"/> Prolonged jaundice | <input type="checkbox"/> Difficulty latching/sucking |
| <input type="checkbox"/> Poor sleeper | <input type="checkbox"/> Formula fed |
| <input type="checkbox"/> Immunizations in hospital | <input type="checkbox"/> Breast fed |
| If yes, specify vaccine: | <input type="checkbox"/> Bottle fed |
| | <input type="checkbox"/> Colic |

Weight at birth: _____

Length at birth: _____

Health History

Has your child ever experienced the following or been diagnosed as having any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Illnesses accompanied by a high fever | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Hypoglycemia (low blood sugar) |
| <input type="checkbox"/> Chronic ear infections/earaches | <input type="checkbox"/> Trouble with bladder control (enuresis) |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Serious fall(s) or repetitive falls | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Serious illness | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Allergies to foods | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chemical insensitivities | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Undergone any surgeries | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Neck or back problems | <input type="checkbox"/> Joint or muscle problems |
| <input type="checkbox"/> Adverse reaction to any vaccinations (even if mild) | |
| If yes, please explain: | |

Developmental History

Does or did your child have any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Difficulty with crawling (on all fours) | <input type="checkbox"/> Did not crawl on all fours |
| <input type="checkbox"/> Difficulty learning to ride a bike | <input type="checkbox"/> Appears clumsy |
| <input type="checkbox"/> Difficulty learning to read | <input type="checkbox"/> Difficulty with writing |
| <input type="checkbox"/> Difficulty using utensils | <input type="checkbox"/> Difficulty buttoning clothing |
| <input type="checkbox"/> Difficulty tying shoes | <input type="checkbox"/> Difficulty or awkward with walking/running |
| <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> Difficulty sitting still or paying attention |

At what age did your child start to walk unassisted: _____

Comments: _____

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Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- | | |
|--|--|
| <input type="checkbox"/> Hearing loss or impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Autism/Autism Spectrum Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Other _____ |

Current/Past Medications and Treatment

List any medications that your child is taking:
List names, dosage, frequency

List any supplements that your child takes:

List any special dietary needs that your child has:

List any treatment that your child is currently undergoing with any health professional:

List any special services that your child is currently receiving at school or privately:

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:

Comments: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Mooberry, D.C. to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

Signature and relation of person completing this form

Date

Signature of witness

Date

