PEDIATRIC HISTORY FORM (Birth to Age 8)

Patient Name: _____ SS#: _____

Parents/Guardians: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Birth Date: _____ Birth Weight: _____ Birth Length: _____ Sex: M F

Current Weight: _____ Current Height: _____ Apgar Scores: _____

Purpose for Contacting Us:

_____

_____

Health Concerns:

_____

_____

Complications During Pregnancy:

_____

_____

Number of Ultrasounds: #_____ Medications/Vitamins During Pregnancy: _____
_____ Cigarette/Alcohol Use: Yes No

Complications During Labor:

_____

_____

Complications During Birth:

_____

_____

Location of Birth: Name of HOSPITAL: _____ Name of BIRTHING CENTER: _____
HOME Birth: Yes No Name of Midwife: _____

Medication During Labor: _____

Birth Interventions: FORCEPS VACUUM EXTRACTION CAESARIAN SECTION (Circle what applies)

Emergency or Planned C-Section: _____

Complications During Delivery: _____

Breast Fed: Yes No How Long: _____ Currently Breast Feeding: Yes No

Difficulties with Breast Feeding (explain):

_____

_____

Formula Fed: Yes No Type: _____

Difficulties with Formula Feeding (explain): _____

Food/Juice Allergies or Intolerances: _____

Genetic Disorders or Disabilities: _____

Did Your Child Fall from a High Place: Yes No Explain:

_____

Has your Child been in a Car Accident or Suffered from Athletic Injuries: Yes No Explain:

_____

Has Your Child had other Traumas: Yes No Explain:

_____

Are/Were there Problems with Development (Mark Yes or No):

____Difficulties Responding to Sound or Parent's Voice

____Not Interested in Visual Stimuli

____Difficulties with Holding up Head

____Difficulties with Belly Time

____Difficulties with Rolling (either not rolling, or rolling only one way)

____Difficulties with Sitting on Own

____Difficulties with Crawling (belly crawl or skipped entirely)

____Difficulties with Standing Alone

____Delayed Walking (18 Months or later)

____Delayed Speech

Additional Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Number of Doses of Antibiotics and Other Prescription Medication Your Child Has Taken:

In Their Lifetime: #_____ List: _____

Vaccination History: _____

Authorization for Care of a Minor:

I authorize Beacom Family Chiropractic and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature of Parent/Guardian: _____

Date: _____ Witness: _____