Pediatric History Form

Moliver Chiropractic

Patient Name _____ Date of Birth _____ /_____ / _____

Home Address _____ Age _____

City _____ State _____ Zip _____

Social Security Number _____ ☐ Male ☐ Female Height _____ Weight _____

Name of Parent / Guardian _____

Home Phone _____Work Phone _____Cell Phone _____

Email Address _____

Referred by _____

Reason for contacting us? _____

Other doctors seen for this condition: ☐ Yes ☐ No

Doctors' names and prior treatments: _____

_____

Other health problems: _____

Check 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	☐ ADD/ADHD	☐ Recurring fevers	☐ Growing / Back pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper tantrums	☐ Other _____

Previous Chiropractor: _____

Date of last visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____/_____/_____ Reason: _____

Are you satisfied with the care your child has received there? ☐ Yes ☐ No

Number of doses of antibiotics your child has taken in the last six months? _____

Has your child been vaccinated (optional)? ☐ Yes ☐ No

Prenatal History

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ☐ Yes ☐ No List _____

Medications during pregnancy / delivery? ☐ Yes ☐ No List _____

Cigarette / Alcohol use during pregnancy? ☐ Yes ☐ No

Location of birth: ☐ Hospital ☐ Birthing center ☐ Home

Birth intervention: ☐ Forceps ☐ Vacuum extraction ☐ Ceasarian section (☐ Emergency ☐ or Planned)

over →

Complications during delivery? ☐ Yes ☐ No List _____

Genetic disorders or disabilities? ☐ Yes ☐ No List _____

Birth weight: _____ pounds _____ ounces

Other History

Food / Juice allergies or intolerances? ☐ Yes ☐ No List _____

_____

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No List _____

_____

Has your child ever been involved in a car accident? ☐ Yes ☐ No List _____

Has your child ever been seen on an emergency basis? ☐ Yes ☐ No List _____

Other traumas not described above? ☐ Yes ☐ No List _____

Prior surgery? ☐ Yes ☐ No List _____

_____

Childhood Diseases

Chicken Pox	☐ Yes	☐ No	Age _____	Mumps	☐ Yes	☐ No	Age _____
Rubella	☐ Yes	☐ No	Age _____	Whooping Cough	☐ Yes	☐ No	Age _____
Rubeola	☐ Yes	☐ No	Age _____	Other _____	☐ Yes	☐ No	Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Authorization for care of minor

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance _____ Policy # _____

Patient's Signature _____ Date _____ /_____ /_____

Signature of Parent or Guardian _____ Date _____ /_____ /_____