WESTCHASE
CHIROPRACTIC AND WELLNESS

# PEDIATRIC HISTORY FORM

Childs Name_________________________________________ Today's Date _____/_____/____

Date of Birth _____/_____/______ Birth Height: _______ Birth Weight: _______

Current Height: ______ Current Weight: _____ Age: _____

Address _________________________________________________________

City _____________________ State _______ Zip _________

Phone (Home) _____________________

Parent's Email ______________________________________________________

Pediatrician/Family MD _____________________________________

City & State ___________________________

Last Visit: ____/____/____

Reason for visit:___________________________________________________________

**CHILD'S CURRENT PROBLEM:**

**Purpose of this visit:** _____Wellness Check-up _____Injury or Accident _____Other
Please explain:

_______________________________________________________________________________

_______________________________________________________________________________

______________________________________________________________________________

*Current medications/ vitamins/supplements your child is taking:*

_______________________________________________________________________________

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______________________________________________________________________________

______________________________________________________________________________

*If your child is experiencing* ***Pain/Discomfort please identify where and for how long***

______________________________________________________________________________

______________________________________________________________________________

1. **When did the** Problem first begin? Date ____/____/______ _____Unknown
   _____Gradual _____Sudden

2. **Ever had** this problem **before**? No ______Yes______
   If yes when? _____________________________________________

3. Any **bowel or bladder** problems since this problem began?: If yes,
   *(Describe)*:___________________________________________________________________
   __________________________

4. Have you seen any **other doctors** for this problem? No Yes
   If yes who? ______________________________________

5. How long ago? ________Days ________ Weeks _________ Months ________Years

6. What were the results of past treatment?
   __________________________________________________________________

7. How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same
   ☐ Gradually Worsening ☐ On & Off

8. Has your child ever sustained an injury playing organized sports? _______if yes please
   explain:____________________________________________________________________

______________________________________________________________________________

9. Has your child ever sustained an injury in an auto accident? _______ if yes, please
   explain:____________________________________________________________________

10. Current Diet: ______________________________________________________________

______________________________________________________________________________

11. Any diet restrictions? _______________________________________________________

12. Vaccine History: Yes No Partially

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Explain: ______________________________________________

13. What was your child's birthing process like? Circle one- Vaginal C-Section

Please describe:_________________________________________________________________

_____________________________________________________________________________

**HAS YOUR CHILD EVER SUFFERED FROM:** *Check All That Applies*

□ Headaches □ Orthopedic Problems □ Digestive Disorder □ Behavioral Problems

□ Dizziness □ Neck Problems □ Poor Appetite □ Learning Disabilities

□ Fainting □ Arm Problems □ Stomach Ache □ ADD/ADHD

□ Sensory Concerns □ Leg Problems □ Reflux □ Ruptures/Hernia

□ Concussion □ Joint Problems □ Constipation □ Muscle Pains

□ Spectrum Disorder □ Backaches □ Diarrhea □ Growing Pains

□ Brain & Spinal Cord Injury □ Poor Posture □ Hypertension □ Allergies to ___________

□ Seizures/Convulsions □ Anemia □ Colds/Flu □ Asthma

□ Heart Trouble □ Colic □ Broken Bones □ Bed Wetting

□ Chronic Earaches □ Sinus Trouble □ Scoliosis □ Fall off bicycle

□ Walking Troubles □ Sleeping Troubles □ Fall in baby walker □ Fall from high chair

□ Fall from bed or couch □ Fall from crib □ Fall off swing

□ Fall off slide □ Fall down stairs □ Fall from changing table

□ Fall off monkey bars □ Fall off skateboard/skates

□ Other: ______________________

Parent/Guardian Signature: __________________________________

Parent/ Guardian Print: _____________________________________

Date: ____________________

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