PEDIATRIC PATIENT HISTORY

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Child's Name:____
Last First MI
DOB: ______________ Age:____ 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
Number of Siblings: ________
Referred By:_________________________________ Purpose of this appointment: __________________________
Email:_______________________________________ Would you like to be added to our email list? ❑ yes ❑no

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

Obstetrician / Midwife: ____
Pediatrician / Family MD: ____
Date of last visit: ___/___/___ Purpose: ____
Immunization History:____
Number of doses of antibiotics your child has taken: During last 6 months ______ During his/her lifetime: ______
Previous Chiropractor: ____
Date of Last Visit: ___/___/___ Purpose: ____
Has your child ever been treated on an emergency basis? ❑ yes ❑ no
If yes, please explain: ____

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

- ❑ Hospital birth
- ❑ Birthing home
- ❑ Long and/or difficult labor
- ❑ Placenta previa
- ❑ Forceps or suction cup used
- ❑ Fetal distress
- ❑ Elective c-section
- ❑ The child was a "blue baby"
- ❑ Other problems during pregnancy?____
- ❑ Home birth
- ❑ The labor was induced
- ❑ The delivery was rapid
- ❑ Breech birth
- ❑ Cord around the neck
- ❑ Emergency c-section
- ❑ The child was premature (2+ weeks)

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

- ❑ Required resuscitation/oxygen
- ❑ Prolonged jaundice
- ❑ Distorted skull
- ❑ Difficulty latching / sucking
- ❑ Formula fed
- ❑ Bottle fed
- ❑ Breast fed
- ❑ Colic

Congenital Anomalies/Defects? ❑ yes ❑ no If Yes, please explain:_________________________________

Number of hours sleeping per night? ___________________ Quality of sleep: ❑ Good ❑ Fair ❑ Poor

Birth weight: _________ Birth Length:_________ Current Weight: _________ Current Length: _________

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

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures/Convulsions
- ❑ Chronic ear infections/earaches
- ❑ Head injury
- ❑ Auto Accident
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Undergone any surgeries
- ❑ Neck or back problems
- ❑ Adverse reaction to any vaccinations (even if mild)
- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (enuresis)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Rheumatic Fever
- ❑ Joint or muscle problems

If yes, please explain: _____

Developmental History
Does or did your child have any of the following:

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

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

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

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

Current/Past Medications and Treatment

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

_____
_____

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

_____
_____

List any supplements that your child takes:

_____
_____

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

_____
_____

_____ _____

Has this child ever suffered the following spinal traumas?

❑ Fall in baby walker	❑ Fall from bed or couch	❑ Fall off skateboard or skates
❑ Fall from crib	❑ Fall off swing	❑ Fall off bicycle
❑ Fall from highchair	❑ Fall off slide	❑ Fall down stairs
❑ Fall from changing table	❑ Fall off monkey bars	❑ Sports related injury

❑ Other _____

Comments:_____
_____
_____
_____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Amanda Jerviss, D.C. to evaluate and treat my son/daughter as she deems necessary, including administering any necessary x-rays.
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**