

Capstone Chiropractic Pediatric History Form

Child's Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Child's SS#: _____ Family Email Address: _____

Age (years) _____ (months) _____ Date of Birth ____/____/____ M / F

Purpose of this appt.: _____

Mother's Name: _____ Phone: (H) _____ (W) _____

Employer: _____ Occupation: _____

Father's Name: _____ Phone: (H) _____ (W) _____

Employer: _____ Occupation: _____

Is the child covered by any health insurance? Y / N

Insurance Company Name(s): _____

Siblings and ages: _____

Please check any past and present symptoms:

<input type="checkbox"/> Allergies/Asthma <input type="checkbox"/> Arm Problems <input type="checkbox"/> Backaches <input type="checkbox"/> Bed wetting <input type="checkbox"/> Behavior problems <input type="checkbox"/> Broken bones <input type="checkbox"/> Colds/Flu <input type="checkbox"/> Colic <input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Digestion problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Ear infections <input type="checkbox"/> Headaches <input type="checkbox"/> Heart trouble <input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Leg Problems <input type="checkbox"/> Neck Problems <input type="checkbox"/> Scoliosis <input type="checkbox"/> Seizures <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Temper Tantrums <input type="checkbox"/> Walking problems <input type="checkbox"/> Car accident <input type="checkbox"/> Other _____ _____ _____
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Name of Pediatrician: _____ Date of last visit: _____

Reason: _____

Birth Intervention:

- Normal vaginal delivery
- Forceps
- Vacuum Extraction
- Caesarian Section: ___Planned ___Emergency
- Complications during delivery: Yes / No
- Genetic disorders or disabilities: Yes / No

Birth Weight: _____ Birth Length: _____

Present Weight: _____ Present Length/Height: _____

Feeding History:

Breast Fed Yes / No

Formula Fed Yes / No

Vaccination History:

- My child's vaccinations are up to date
- My child has not received any vaccinations
- I do not know if my child was vaccinated
- My child had an adverse reaction to a vaccination

Authorization for Care of Minor: I hereby authorize this office and it's doctors and assistants to administer care to my child as they deem necessary.

Signed: _____ Date: ___/___/___

Witnessed _____ Date: ___/___/___

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family more comfortable.

We look forward to working with you to build better health for your family.