MALAMA CHIROPRACTIC CLINIC
PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our family of Chiropractic Patients. Please complete the following information for us. We look forward to working with you to build better health for your family.

Patient Name: ______________________ SSN: ______________

Address: ______________________ City: ______________

State: __________ Zip Code: ______ Home Phone: ______________

BirthDate: ____/____/____ Sex: ______ Weight: ________ Height: ________

Name of Parents/Guardian: ______________________

Purpose for Contacting Us: ______________________

Other Doctors Seen for this Condition: ______________________

Approximate Dates Seen: ______________________

Check any of the Following Conditions your Child has suffered during the last Six Months:

____ADHD ___Asthma ____Allergies ____Bed Wetting ____Car Accident

____Colic ____Chronic Colds ____Digestive Problems ____Ear Infection

____Growing Pains ____Headaches ____Recurring Fevers ____Seizures

____Temper Tantrums

Previous Chiropractor: ______________________

Date of Last visit: __________ Reason for Visit: ______________________

Name of Pediatrician: ______________________

Date of Last visit: __________ Reason for Visit: ______________________

Number of Doses of Antibiotics your Child has Taken:

During the Last 6 Months: __________

Total During His/Her Lifetime: __________

Number of Doses of OTHER PRESCRIPTION MEDICATIONS Your Child has taken:

During the Last 6 Months: __________

During His/Her Lifetime: __________ Please List : ______________________

Vaccination History: ______________________

Name of Obstetrician/Midwife: ______________________

Complications During Pregnancy: ______________________

Ultrasounds During Pregnancy (Please Circle: YES NO Number of Ultrasounds: ________

Medications Taken During Pregnancy (Please List): ______________________

Cigarettes/Alcohol Use During Pregnancy (Please Circle): YES NO

Location of Birth ________Hospital ________Birthing Center ________Home

Birth Intervention: Forceps ______ Vacuum Extraction

______ Ceasarian Section -----EMERGENCY OR PLANNED

Complications During Delivery (Please Circle): YES NO Please List: ______

______

Genetic Disorders or Disabilities: YES NO : List ______

Birth Weight: ______ Birth Length: ______ APGAR Scores ______

Breast Fed: YES NO : How Long: ______

Formula Fed: YES NO : How Long: ______

Introduced to Solid Food: ______ Months Cow's Milk: ______ Months

Food/Juice Allergies or Intolerances: YES NO :List: ______

DEVELOPMENT HISTORY:
During the following times, your Child's Spine is most vulnerable to stress, and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of Vertebral Subluxation (Spinal Nerve Interference). At what age was your Child able to:

______ Respond to Sound ______ Respond to Visual Stimuli ______ Hold their Head up

______ Sit Up ______ Cross Crawl ______ Stand Alone ______ Walk Alone

According to the National Safety Council, approximately 50% of Children fall head first from a high place During their first year of life. (For example: a bed, changing table, down stairs, etc.)

Was this the case with your Child? ______

Has your Child ever been involved in a Car Accident? ______

Has your Child ever been seen on an Emergency Basis? ______

Any other Traumas not Described Above? ______

Any Prior Surguries? YES NO Please List and Describe: ______

______

CHILDHOOD DISEASES:

Chicken Pox YES NO AGE ______ Rubella YES NO AGE ______

Rubeola YES NO AGE ______ Mumps YES NO AGE ______

Whooping Cough YES NO AGE ______ Other YES NO AGE ______

I Authorize Malama Chiropractic 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 and charges incurred by my Child at this office.

Signature of Parent/Guardian ______ Date ______