PRENTICE Family CHIROPRACTIC LLC

Date: ____________________

PEDIATRIC PATIENT HISTORY

Child's Name: ______________________________ SS# ____________________
Last First MI.

DOB: __________ Sex: ______ Grade in School: __________ Home Phone: ____________________

Address: ____________________ City: ______________ State: ________ Zip: __________

Mother's Name: ______________ Cell/Work Phone: ______________ Email: ______________

Father's Name: ______________ Cell/Work Phone: ______________ Email: ______________

Referred By: ______________ Purpose of Appointment: ____________________

Pregnancy History (Mother)

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

Did you experience any of the following during your pregnancy:

- ☐ Severe viral infection during first trimester
- ☐ Alcohol/drug use
- ☐ Breech position during pregnancy
- ☐ Hypertension
- ☐ Smoking
- ☐ Toxoplasmosis
- ☐ Severe stress
- ☐ Diabetes
- ☐ Pre-eclampsia
- ☐ Toxemia

Labor and Delivery History

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

- ☐ Hospital birth
- ☐ Home birth
- ☐ Induced labor
- ☐ Long/difficult labor
- ☐ Rapid delivery
- ☐ Placenta previa
- ☐ Breech birth
- ☐ Forceps or suction cup used
- ☐ Cord around neck
- ☐ Fetal distress
- ☐ Emergency C-section
- ☐ Elective C-section
- ☐ Premature delivery (2+ weeks)
- ☐ Child was a "blue baby"

Newborn History

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

- ☐ Required oxygen
- ☐ Distorted Skull
- ☐ Prolonged jaundice
- ☐ Difficulty latching/sucking
- ☐ Poor sleeper
- ☐ Formula fed
- ☐ Breast fed
- ☐ Colic

Weight at birth: ______________

Comments: ____

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Health History

Did the child experience the following or been diagnosed as having any of the following:

- ☐ Illness accompanied by high fever
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Diabetes
- ☐ Seizures
- ☐ Hypoglycemia
- ☐ Chronic ear infections
- ☐ Head injury
- ☐ Trouble with bladder control
- ☐ Serious falls
- ☐ Serious illness
- ☐ Epilepsy
- ☐ Asthma
- ☐ Meningitis
- ☐ Sinus problems
- ☐ Allergies to food
- ☐ Constipation
- ☐ Environmental allergies
- ☐ Diarrhea
- ☐ Digestive disorders
- ☐ Surgeries
- ☐ Rheumatic fever
- ☐ Neck or back problems
- ☐ Joint or muscle problems
- ☐ Adverse reaction to vaccination

Developmental History

Does or did your child have any difficulty with any of the following:

- ☐ Crawling on all fours
- ☐ Learning to ride a bike
- ☐ Writing
- ☐ Learning to read
- ☐ Appears clumsy
- ☐ Using utensils
- ☐ Buttoning clothing
- ☐ Tying shoes
- ☐ Walking/running
- ☐ Hand/eye coordination
- ☐ Sitting still
- ☐ 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:

- ☐ Hearing loss
- ☐ Visual Impairment
- ☐ Neurological disorders
- ☐ Anxiety/Depression
- ☐ Dyslexia
- ☐ Sensory Processing Disorder
- ☐ Autism Spectrum Disorder
- ☐ ADD/ADHD
- ☐ Tourette's Syndrome
- ☐ Obsessive Compulsive Disorder (OCD)

Current/Past Medications and Treatment

List any medications your child is taking:

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List any special dietary needs:

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____

List any supplements your child is taking:

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____

List any treatment your child is currently receiving:

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List any special services your child is currently receiving at school or privately: ____

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AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Prentice to evaluate and treat my son/daughter as they deem necessary.
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.

____ ________________

Signature and relation of person completing this form **Date:**