HealthSource™
Chiropractic & Progressive Rehab™

Pediatric/Infant Supplemental History

Patient Name_______________________________ SS#__________________
Name of Parents / Guardians______________________________________
Address _________________________________City _______________State _____Zip___________
Home Phone_______________ Work Phone_________________ Email
Address___________________
Birth Date ___________ Sex______ Weight___________ Height_______ Number of siblings_______
Who referred you to us? ____
Reason for seeking chiropractic care**:** ____
Other Doctors seen for this condition Yes/No Specialty:_____________________________________
Prior treatment and outcome: ____
Other Health Problems: ____

Symptoms: Please circle any current or past problems your child has on the list below:

Dizziness	Runny Nose	Poor Appetite	Arm/Elbow Pain
ADHD	Itchy Eyes	Hyperactivity	Leg/Hip Pain
Backaches	Rashes	Behavioral	Knee/Foot Pain
Heart Condition	Unusual Moles	Poor Memory	Growing pains
Chronic Earaches	Neuritis	Insomnia	Joint Pain
Diabetes	Digestive	Nightmares	Scoliosis
Tuberculosis	Sinus Trouble	Bed Wetting	Blood disorders
Hypertension	Cough/Wheeze	Pain Urinating	Stomach Aches
Fever/Chills	Chest Pain	Convulsions	Other
Frequent Colds	Constipation	Paralysis	_____________
Arthritis	Anemia	Muscle Pain	_____________
Headaches	Fainting	Broken bones	_____________
Asthma	Rheumatic Fever	Sprains/Strains	
Allergies	Diarrhea	Neck Pain	

Notes____
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Health History:
Name of Pediatrician: ______________________________________ Date of last visit ____________
Reason for visit: ____
Medications and conditions being treated: ____
Has your child ever taken antibiotics? Yes/No Condition treated: __________________________________
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Yes/NoIf yes, describe (Sprain, Broken Bone, Head Trauma…) ______________________________________

_____________________ _____________ ______ _________________________
Signature Relationship Date Physician Signature

Has your child ever been involved in a car accident? Yes/No Date & Injuries ___________________________
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Yes/No ______________________
Other traumas not described above? Yes/No Type & Date: ____
Prior surgery: Yes/No Type and Date:_______________________________ Menarche: Yes/No Age:________

Prenatal History

Location of Birth: Home/Birthing Center/Hospital   Is the Child: Stepchild/Adopted
Complications during pregnancy: Yes/No List: ____
Ultrasounds during pregnancy: Yes/No Number: __________
Medications during pregnancy/delivery: Yes/No List: ____
Cigarette / Alcohol use during pregnancy: Yes/No
Birth intervention: O Forceps O Vacuum O Caesarian, Why?______________________________________
Complications during delivery: Yes/No List: ____
Genetic disorders or disabilities: Yes/No List: ____
Birth weight________ Birth length_________ APGAR scores (if known): 1 min _____ 5 min _____

Feeding history

Breast Fed: Yes/No How long'?___________ Formula fed: Yes/No How long'?___________
Introduced to: solids at _____ months.   Cow's milk at _____ months
Food / juice allergies or intolerances Yes/No List: ____

Developmental History

Sleep (Hrs per night) _______ Naps (number & lengths) _____________ Problems sleeping __________
At what age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases (Please Circle)

Chicken Pox - Age ___   Mumps - Age ___   Rubella - Age ___   Whooping cough - Age ___
Measles - Age ___   Meningitis - Age ___   Tuberculosis - Age ___   Other - Age _________

Vaccination History (Please Circle):

HBV / Hep B (Hepatitis B) – Age __
DTP (Diphtheria, Tetanus, Pertussis) – Age __
HbCV / Hib (H. influenzae type b conjugate) – Age __
OPV (Oral Polio Vac) or IPV (Inact. Poliovirus) – Age __
MMR (Measles, Mumps, Rubella) – Age __
Varicella (Chicken Pox) – Age __
PCV (Pneumoccocal) – Age __
Adverse Reactions to Any Vaccine?   Yes/No List: ____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, ___________________________, being the parent or legal guardian of ___________________________
hereby grant permission for my child to receive chiropractic care.

Signed: ____________________ Date: _____ Witnessed ____________________ Date: _____
Physician Signature____   Date: _____