

PEDIATRIC PATIENT HISTORY

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**Child's Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade In School:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Home Phone:** (\_\_\_\_) \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City/Town:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Mother's Name:** \_\_\_\_\_ **Cell/Work Phone:** \_\_\_\_\_ / \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ **Cell/Work Phone:** \_\_\_\_\_ / \_\_\_\_\_  
**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:

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

Newborn History

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

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Required resuscitation/oxygen | <input type="checkbox"/> Formula fed |
| <input type="checkbox"/> Prolonged jaundice | <input type="checkbox"/> Bottle fed |
| <input type="checkbox"/> Distorted skull | <input type="checkbox"/> Breast fed |
| <input type="checkbox"/> Difficulty latching / sucking | <input type="checkbox"/> 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:

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

If yes, please explain: _____

Developmental History

Does or did your child have any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Difficulty with crawling (on all fours) | <input type="checkbox"/> Did not crawl on all fours |
| <input type="checkbox"/> Difficulty learning to ride a bike | <input type="checkbox"/> Appears clumsy |
| <input type="checkbox"/> Difficulty learning to read | <input type="checkbox"/> Difficulty with writing |
| <input type="checkbox"/> Difficulty using utensils | <input type="checkbox"/> Difficulty buttoning clothing |
| <input type="checkbox"/> Difficulty tying shoes | <input type="checkbox"/> Difficulty or awkward with walking/running |
| <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Hearing loss or impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Autism/Autism Spectrum Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Other _____ |

Current/Past Medications and Treatment

List any medications that your child is taking:

List names, dosage, frequency

List any supplements that your child takes:

List any treatment that your child is currently

undergoing with any health professional:

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