



## PEDIATRIC HEALTH SURVEY (Please Print)

Child's Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:  M  F

Name of Parent(s)/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone Number: (\_\_\_\_) \_\_\_\_\_

Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Home Phone Number: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ @ \_\_\_\_\_

How did you hear about our office?  
\_\_\_\_\_

Reason for Visit:  Wellness Check-Up  Health Concern

Please briefly explain your health concern:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you seen other doctors for this condition?  Yes  No

Who was the physician? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Results: \_\_\_\_\_

Is minor experiencing any other health problems or concerns?  Yes  No

Explain briefly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check any of the following that your *CHILD* has suffered from during the past 6 months:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> ADD/ADHD         |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Colic              | <input type="checkbox"/> Recurrent Fevers |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Temper Tantrums  |
| <input type="checkbox"/> Car Accident       | <input type="checkbox"/> Neck/Back Pain     |   |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Chronic Cold/Sinus |   |
| <input type="checkbox"/> Other              |   |   |

Explain: \_\_\_\_\_

Has any other family member suffered from these symptoms? Yes No

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ For what reason: \_\_\_\_\_

Name & telephone # of current pediatrician: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ Reason: \_\_\_\_\_

**Number of doses of antibiotics your child has taken:**

During the past 6 months: \_\_\_\_\_

List of Antibiotics: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any adverse reactions to vaccinations?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Prenatal History:**

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy? No Yes

Please Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Ultrasounds during pregnancy? No Yes Number of sessions: \_\_\_\_\_

Medications during pregnancy/delivery?  No Yes

List: \_\_\_\_\_

Cigarette/Alcohol Use during pregnancy: No Yes

Location of Birth:  Hospital  Home  Birthing Center

Birth Intervention:       Forceps                       Vacuum Extraction  
                                  Caesarian `                       Emergency                       Planned

Were there any complications during delivery:  No  Yes

Please explain in detail:

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Genetic Disorder or Disabilities:  No  Yes

Please explain:

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Birth Weight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

Birth Length: \_\_\_\_\_ inches

APGAR Scores \_\_\_\_\_

### Feeding History:

Breast Fed:               No  Yes                      How Long: \_\_\_\_\_

Formula Fed:               No  Yes                      How Long: \_\_\_\_\_

Type/Brand: \_\_\_\_\_

Introduced solids at: \_\_\_\_\_ months              Cow's Milk at: \_\_\_\_\_ months

Food/Juice Allergies or Intolerances?       No  Yes

List: \_\_\_\_\_

### Developmental 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 Head Up

\_\_\_\_\_ Cross Crawl      \_\_\_\_\_ Sit Up      \_\_\_\_\_ 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 (i.e. bed, changing table, down stairs, etc...).*

Was this the case with your child?               No  Yes

Is/was your child involved in any high impact or contact sports?  No  Yes

*(i.e. football, soccer, gymnastics, baseball, basketball, cheerleading, martial arts, etc...)*

Sport(s): \_\_\_\_\_

Has your child ever been involved in a car accident? No Yes

List: \_\_\_\_\_

Has your child ever been seen on an emergency basis? No Yes

List: \_\_\_\_\_

Other Traumas not listed above?  No Yes

List: \_\_\_\_\_

Prior Surgery? No Yes List: \_\_\_\_\_

Menarche? No Yes At what age: \_\_\_\_\_

**Childhood Diseases:**

Chicken Pox: No Yes – Age: \_\_\_\_\_ Mumps: No Yes – Age: \_\_\_\_\_

Rubella: No Yes – Age: \_\_\_\_\_ Rubeola/Measles: No Yes – Age: \_\_\_\_\_

Whooping Cough: No Yes – Age: \_\_\_\_\_

Other (Explain):

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR CARE OF A MINOR & FINANCIAL AGREEMENT**

I hereby authorize the doctor to treat my child’s condition, as he/she deems appropriate. I have read the Informed Consent to Chiropractic Treatment form and have fully evaluated the risks and benefits of my child undergoing treatment and give permission for such treatment.

I hereby authorize this office and its Doctors to administer care for my son/daughter as they deem necessary and I understand and agree that I am personally responsible for payment of all fees charged by this office. Additionally, the AHCC billing department will work diligently on my behalf with my insurance company, attorney, or any other party to seek reimbursement where applicable.

Name of Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group# \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_