Pediatric History Form

Levi J. Pulver, D.C., PLLC • 17208 Van Wagoner Rd • Spring Lake, MI 49456 • www.pulverchiropractic.com

Date: ______________

Name: ______________________________________ **Address**: ____

City, State, Zip: ______________________________ **Home Phone**: ____________________________

D.O.B.: __________ **Sex:** __________ **Weight:** __________ **Height:**__________

Name of Parents/Guardians: ____

Referred By: ____

Purpose for Contacting us? ____

Other Doctors seen for this condition? No Yes (Name: _________________________)

Other Health Conditions? __________________________

Circle any of the following conditions your child has suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing/Back Pains
Colic	Bed Wetting	Car Accident	Temper Tantrums	Other: ____________

Previous Chiropractor: ______________________________ **Date of Last Visit:** ____/____/____

Reason: ____

Name of Pediatrician: _______________________________ **Date of Last Visit:** ____/____/____

Reason: ____

Number of doses of antibiotics your child has taken?
During the past 6 months: ______ , Total during his/her lifetime: ______

Number of other doses of other prescription medications:
During the past 6 months: ______ , Total during his/her lifetime: ______ List: ___________________________

Vaccination History: ____

Prenatal History

Complications during pregnancy? No Yes (____)

Ultrasounds during pregnancy? No Yes (______)

Medications during pregnancy/delivery? No Yes (____)

Cigarette/Alcohol use during pregnancy? No Yes

Name of Obstetrician/Midwife: ___________________ **Location of birth:** Home Birthing Center Hospital

Birth Intervention(s): Forceps Vacuum Extraction Caesarian Section(emergency or planned?)

Complications during delivery? No Yes **Genetic disorders or disabilities?** No Yes

Birth Weight: ________ **Birth Length:** _______ **APGAR Scores:** _______, _______

Feeding History

Breast fed: No Yes (How Long: ______)
Formula fed: No Yes (How Long:_______)

Introduced to **solids** at _______ months, **cow's milk** at _______ months

Food/Juice Allergies or Intolerances:

No Yes (____)

Developmental History

During the following times your child's spine is most vulnerable to stress and should routinely be 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
______ 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 (I.e. A bed, changing table, stairs, etc.) **Was this the case with your child?** No Yes

Is/Has your child been involved in any high impact or contact sports (I.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, etc) ? No Yes (____)
Has your child ever been involved in a car accident? No Yes (______________________________)
Has your child been seen on an emergency basis? No Yes (______________________________)

Other Traumas not described above? ____

Prior Surgery: No Yes (____)
Menarche: No Yes (age: _______)

Childhood Diseases:

Chicken Pox	(N / Y age ____)	Mumps	(N / Y age ____)
Rubella	(N / Y age ____)	Whooping Cough	(N / Y age ____)
Rubeola	(N / Y age ____)	Other:____________	(N / Y age ____)

We are here to serve you and encourage you to ask questions.
Your participation is vital and will help determine your results.
Authorization for care of minor

I hereby authorize this office 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 charged by this office.

Signed: ____ Date: ______/______/______

Witnessed: _____________________________________ Date: ______/______/______