

**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: \_\_\_/\_\_\_/\_\_\_

Is it ok if we send him/her updates on your child's care? \_\_\_\_\_

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          | _____ Cross Crawl |
| _____ Respond to Visual Stimuli | _____ Stand Alone |
| _____ Hold Head Up              | _____ Walk Alone  |
| _____ Sit Up                    |                   |

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 (\_\_\_\_\_)

**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 understand that no cures are promised (or implied) and results are not guaranteed. I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I now authorize Dr.Pulver to proceed with any necessary treatments for my son/daughter. I have read Dr. Pulver's office policies and consent to treat information, and I agree with them by signing below:*

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witnessed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_