Simmons Specific Chiropractic

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Pediatric Health History Form

****Please print in black ink**

Date: _____

Patient's Name: _____ S.S. #: _____ /____ /_____

Date of Birth: ____/____/____ Age: _____ Race: Caucasion / African American /

Sex: M / F Height: _____ Weight: _____ Other: _____

Previous Chiropractic Care? Y / N Ethnicity: Non Hispanic / Hispanic

Date of last visit: _____ Preferred Language: _____

Parents'/Guardians' Names: _____

Parent's/Guardian's Date of Birth: ____ /___ /____ S. S. # _____ /____ /_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Relationship to Child:_____ Guardian Email:_____

( ) Mom ( ) Dad ( ) Legal Guardian ( ) Grandma ( ) Grandpa

Insurance Information

Primary Insurance: _____ Insured's Name: _____

Insured's Birth Date: ____/____/____ Insured's Social Security #____/____/____

Secondary Insurance: Y / N Insured's name: _____

Insured's Birth Date: ____/____/____ Insured's Social Security #____/___/____

Child's Health History

Purpose for Contacting Us: _____

Other Doctor(s) Seen for This Condition? Y / N Doctor's Name: _____
Treatment: _____

Life changing events, hospitalizations or surgeries: _____

_____

On-going Health problems: _____

Previous Chiropractic Care? Y / N Doctor's Name: _____
Date: _____

Pediatrician's Name: _____

Date of Last Visit: _____ Reason: _____

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, down stairs, etc.) Was this the case with your child? Y / N

If Yes, What Occurred: _____

Number of Doses of Antibiotics Your Child has Taken in the Last Six Months: _____

Number of Doses of Prescriptions Your Child has Taken in the Last Six Months: _____

Vaccination History: _____

Allergies/Reactions to Medicines or Vaccinations: _____

Vitamins: _____ Home Remedies: _____

Child's Prenatal History

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? Y / N If Yes, List: _____

Ultrasounds During Pregnancy? Y / N If Yes, How Many? _____

Medications Taken During Pregnancy/Delivery? Y / N
If Yes, List: _____

Cigarette/Alcohol Use During Pregnancy? Y / N

Birth Location: ( ) Hospital ( ) Birthing Center ( ) Home

Delivered By: ( ) Vaginal Birth ( ) Caesarian

Birth Intervention: ( ) Forceps ( ) Vacuum Extraction

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

If Premature, How Early? _____

Genetic Disorders or Disabilities? Y / N If Yes, List: _____

Nutrition and Feeding:

Was Your Child Breastfed? Y / N How Long: _____

Was Your Child Formula Fed? Y / N How Long: _____

Introduced to Solids at: _____Months Cow's Milk at: ____Months

Has Your Child Had Any Unusual Feeding/Dietary Problems? Y / N
If yes, specify: _____
Food/Juice Allergies or Intolerances? Y / N If Yes, List: _____

Sleep:

Hours per night: _____ Naps (number and length): _____

Any sleep problems: _____

Developmental History

Do you have a family history of:

Yes	No		Yes	No	
___	____	Heart Trouble	___	____	Nervous Conditions
___	____	Cancer	___	____	Depression
___	____	Inherited Disease			

Review of Organ Systems:

Eyes
___Squinting/Crossed Eyes

Ears/Nose/Throat
___Hard of Hearing
___Mouth Breathing/Snoring
___Bad Breath
___Current Runny Nose
___Teeth/Gum Problems

Respiratory
___Cough/Wheezing

Musculoskeletal
___Muscle/Joint Pain

Allergy
___Hay Fever/Itchy Eyes

Skin
___Rashes
___Unusual Moles

Blood/Lymph
___Unexplained Lumps
___Easy Bruising/Bleeding

Gastrointestinal
___Nausea/Vomiting/Diarrhea
___Constipation
___Blood in Bowel Movement

Cardiovascular
___Easily Tired with Exertion
___Shortness of Breath
___Fainting

Genitourinary
___Bed Wetting
___Painful Urination

Neurological
___Headaches
___Weakness
___Clumsiness

Psychiatric/Emotional
___Speech Problems
___Anxiety/Stress
___Problems with Sleep/Nightmares
___Depression
___Nail Biting/Thumb Sucking
___Bad Temper/Breath Holding

Current Observations
___Pulling on Ears
___Ear Infection
___Noticeable Head Tilt
To the: Left / Right
___Colicky
___Constant Crying
___Behavior Changes
___Tenderness
___Change in Sleeping Habits
___Rosy Cheeks
___Pale
___Gunk in Eyes
___Fever/Chills/ Excessive Sweating
___Unexpected Weight Loss/Gain

Consent To Care Of Minor Child:

I acknowledge that I _____ (Print Name) am the parent or legal guardian of _____ (Child's Name) and hereby authorize Dr. Simmons and whomever he may designate to administer chiropractic care as deemed necessary to _____ (Child's Name), who is my _____ (Relationship to Child).

Signature: _____ Date: _____