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## Pediatric Registration and History Form

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Date \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Parent/Guardian's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian's Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

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## INSURANCE INFORMATION

Primary insured's name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Health Ins. Company \_\_\_\_\_ Member ID# \_\_\_\_\_

Group # \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Is the patient covered by additional insurance? \_\_\_ Yes \_\_\_ No

Insurance Co. \_\_\_\_\_ Member ID/Group # \_\_\_\_\_

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## PATIENT CONDITION

Reason for visit \_\_\_\_\_

Date symptoms first appeared \_\_\_\_\_ How? \_\_\_ Gradual \_\_\_ Sudden \_\_\_ Progressive

Have you been treated already for this condition? \_\_\_ Y/N Doctor's name and type of treatment:  
\_\_\_\_\_

Have you ever been treated by a Doctor of Chiropractic? \_\_\_ Y/N Doctor's name \_\_\_\_\_

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## CURRENT HEALTH AND PRENATAL HISTORY

Name of Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care your child has received there? Y/N

Number of doses of Antibiotics your child has taken:  
During the past 6 months: \_\_\_\_\_ During his/her lifetime: \_\_\_\_\_

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

Previous Chiropractors seen: \_\_\_\_\_

Date of last visit \_\_\_/\_\_\_/\_\_\_ Reason: \_\_\_\_\_

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

Complications during pregnancy?  Yes  No, List: \_\_\_\_\_

Complications during delivery?  Yes  No, List: \_\_\_\_\_

Ultrasounds during pregnancy?  Yes  No, Number: \_\_\_\_\_

Medications during pregnancy? Delivery?  Yes  No, List: \_\_\_\_\_

Location of Birth:  Hospital  Birthing Center  Home

Birth Interventions:  Forceps  Vacuum Extraction  Cesarean Section, Emergency or Planned?  
\_\_\_\_\_

Cigarette / Alcohol use during pregnancy: Y / N

Genetic Disorders or Disabilities:  Yes  No, List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

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## FEEDING HISTORY

Breastfed:  Yes  No, How Long: \_\_\_\_\_

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

Introduced Solids at: \_\_\_\_\_ months, Cows milk at: \_\_\_\_\_ months

Food/Juice Allergies or Intolerances:  No  Yes. List: \_\_\_\_\_

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## 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 subluxtion (spinal nerve interference). At what age was your child able to:

\_\_\_\_\_ Respond to Sound      \_\_\_\_\_ Cross Crawl      \_\_\_\_\_ Stand Alone

\_\_\_\_\_ Respond to Visual Stimuli      \_\_\_\_\_ Walk Alone      \_\_\_\_\_ Hold Head Up

\_\_\_\_\_ Sit Up

According to the National Safety Council, approximately 50% of Children fall from a high place during the first year of life (i.e. Bed, Changing Table, Down Stairs, etc.) Was this the Case with your Child?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Is/Has your child been involved in any high impace or contace type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)?  Yes  No, List: \_\_\_\_\_

Has your child been involved in a car accident?  No  Yes, List: \_\_\_\_\_

Has your child been seen on an emergency basis  No  Yes, List: \_\_\_\_\_

Other traumas not described above?  No  Yes, List: \_\_\_\_\_

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

Onset of Menstruation:  Yes  No, Age: \_\_\_\_\_

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## CHILDHOOD DISEASE

Chicken Pox Y/N, Age: \_\_\_\_\_

Mumps Y/N, Age: \_\_\_\_\_

Rubella Y/N, Age: \_\_\_\_\_

Whooping Cough Y/N, Age: \_\_\_\_\_

Rubeola Y/N, Age: \_\_\_\_\_

Hepatitis Y/N, Age: \_\_\_\_\_

Measles Y/N, Age: \_\_\_\_\_

Other Y/N, Age: \_\_\_\_\_