



Pediatric Patient Health History

Today's Date

/ /

Signature of Parent _____

First Name _____ Nick Name _____

Last Name _____ Middle Name _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____

Best Email address to contact you _____

Mother's Name _____ Father's Name _____

Who may we thank for referring you? _____

Date of Birth

/ /

Age _____

Gender (check one) ☐ Male ☐ Female

Health Questionnaire:

Present Complaint (Describe present complaints, if any): _____

When did this begin? _____ Was there an accident or injury involved? Yes No

Has your child had similar complaints in the past? Yes No If yes, when? _____

Did your child receive any treatment at that time? Yes No What type of treatment? _____

Were the results favorable? Yes No

Other Providers:

Who is your child's Pediatrician? _____

Contact Info (Medical practice/phone number): _____

Last Visit? _____

What other practitioners have you brought your child to for this condition or other recent concerns?

Physician Name _____ Phone: _____

Physician Name _____ Phone: _____

General Questions:

1. How many times has your child been prescribed antibiotics in the last 6 months? _____
Total during lifetime _____
2. Has your child received vaccinations? Yes ____ No ____
3. Has your child been involved in an auto accident or suffered any other traumatic injury? Yes ____ No ____
If yes, please explain: _____
4. Has your child had the following childhood diseases: Chicken Pox Y/N age: ____ Rubella Y/N age: ____
Mumps Y/N age: ____ Whooping Cough Y/N age: ____

Developmental History:

1. At what age was your child able to:
Respond to sound _____ Hold head up _____
Cross crawl _____ Stand alone _____
Walk alone _____ Sit up _____
Respond to stimuli _____
2. Did your child suffer a head injury before age 1? _____

Prenatal History:

1. ____ Obstetrician or ____ Midwife name: _____
2. Any complications during pregnancy? Yes ____ No ____
3. How many ultrasounds during pregnancy? _____
4. Medications during pregnancy? Yes ____ No ____ List: _____
5. Cigarettes or alcohol during pregnancy? Yes ____ No ____
6. Birth intervention? ____forceps ____vacuum ____ C-Section
7. Complications during delivery? Yes ____ No ____ Explain: _____
8. Genetic disorders or disabilities? Yes ____ No ____ Explain: _____
9. Birth weight _____ Birth length _____ APGAR _____

Feeding History:

1. Breast fed: Yes ____ No ____ How long? _____
2. Formula fed: Yes ____ No ____ How long? _____
3. Introduced to solid foods: _____ months
4. Cow's milk at _____ months
5. Food/juice allergies or intolerances? Yes ____ No ____ Explain: _____

HIPPA Acknowledgement

I acknowledge that I have read and understand Complete Wellness Chiropractic's HIPPA Notices of Privacy Practices.

Signature: _____ Date: _____

Consent to Treatment

I consent to a professional and complete chiropractic examination and to any radiographic examination and/or massage therapy treatment that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

As a minor, a legal guardian's signature is required below.

Legal Guardian Signature _____ Date: _____