CINCINNATI UPPER CERVICAL AND FAMILY CHIROPRACTIC

Pediatric History Form

Today's Date___/___/___

Name_____ Birthdate___/___/___ Age_____ Male___ Female___
Address_____ City_____ State_____ Zip_____
Home # (_____)_____ Cell # (_____)_____
E-mail address_____
Height _____ Weight _____
Referred By _____
Name of Parents/Guardians _____
Reason for consulting our office_____
_____
Other Doctors seen for this condition _____
Other health problems _____

Check any of the following conditions your child has suffered from:

___Ear Infections	___Digestive Problems	___Chronic Colds	___Headaches/Migraines
___Asthma/Allergies	___Bed Wetting	___Recurring Fevers	___Back Pain
___Colic	___Seizures	___Temper Tantrums	___Neck Pain
___Scoliosis	___ADD/ADHD	___Growing Pains	___Other _____

Previous Chiropractor _____
Name of Pediatrician _____

Does your child take prescription medications? If Yes, which ones and how often? _____
_____
Does your child take Over The Counter (OTC) medication? If Yes, which ones and how often? _____
_____
Does your child take Antibiotics? If Yes, when was the last time and how often? _____
_____
Has your child been vaccinated? If Yes, name all the vaccinations he/she has been given and when. _____
_____

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Prenatal History

List any complications during pregnancy _____
Number of ultrasounds during pregnancy _____
Medications during pregnancy/delivery _____
Cigarette/Alcohol use during pregnancy _____
Circle the location of the birth: Hospital Birthing Center Home Other: _____
Circle any birth intervention: Forceps Vacuum Extraction Caesarian Section (C-Section) – Emergency or Planned
List any complications during delivery _____
Genetic disorders or disabilities _____
Birth Weight _____ Birth Length _____
Was your child breast fed? If Yes, How long? _____ Formula fed? If Yes, How long? _____
According to the National Safety Council, approximately 50% of children fall headfirst from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc…) Was this the case with your child? If Yes, please explain _____
_____
Is/Has your child been involved in any sports (i.e. soccer, gymnastics, baseball, cheerleading, football, martial arts, etc…)?
If Yes, please explain _____
Has your child ever been involved in a car accident? _____
Has your child ever been to the emergency room? _____
Other traumas not described above _____
Any surgeries? If yes, please explain _____

As the legal parent/guardian of _____, I hereby give my permission to Dr. Gina Dalessandro and/or Dr. Brent Owens to render chiropractic care to the above named minor. (A minor is defined as any dependent under the age of 18 years.)

_____ _____

Parent/Legal Guardian (Signature) *Date* *Witness (Signature)* *Date*