180 Health Solutions
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Confidential Pediatric History Form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Date: _____ Referred By: _____

Child's Name:_____ Phone Number: _____

Do you have other immediate household family members who are patients here? Y ○ N ○

If yes, please list them _____

Address:_____ City:_____ State:_____ Zip:_____

Sex: M○ F○ Weight:_____ Height:_____ S.S.#:_____ Birth Date:_____

Name of Parents/Guardians:_____ Phone Number:_____

Email Address of Parents/Guardians:_____

Purpose for Contacting Us?_____

Other Doctors seen for this condition: Y○ N○ If yes, please list doctor's name and prior treatments: _____

_____

Check any of the following conditions your child has suffered from during the past six months:

○ Ear infections	○ Digestive problems	○ Auto Accident	○ Headaches
○ Asthma/Allergies	○ Bed Wetting	○ Chronic Colds	○ Growing/Back pains
○ Colic	○ Seizures	○ Recurring Fevers	○ Other: _____
○ Scoliosis	○ ADHD	○ Temper Tantrums	_____

Family History:_____

Previous Chiropractor:_____ Date of Last Visit:_____ Reason:_____

Were you satisfied? Y N Why? _____

Previous / Current Pediatrician:_____ Date of Last Visit:_____ Reason:_____

Number of doses of antibiotics your child has taken:

a) During the past six months:_____

b) Total during his/her life:_____

Number of doses of other prescription medications your child has taken:

c) During the past six months:_____

d) Total during his/her life:_____

Vaccination History: _____

Feeding History

Breast Fed: Y N If yes, how long?_____ Formula: Y N If yes, how long:_____

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances: Y N

If Yes, please list:_____ Other allergies or tolerances: Y N If Yes, please list:_____

Number of Hours Sleeping per Night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Prenatal History:

Name of obstetrician/midwife: _____ Pediatrician / Family MD: _____

Birth intervention: Forceps_____ Vacuum Extraction: _____ Caesarian Section: _____ Emergency or Planned?: _____

Ultrasounds during pregnancy? Y N If yes, how many:_____

Medications during pregnancy/delivery? Y N If Yes, please list them:_____

Cigarette/alcohol use during pregnancy? Y N

Childhood Diseases:

Chicken Pox: ◯ Age:_____ Rubeola: ◯ Age:_____ Whooping Cough: ◯ Age:_____

Rubella: ◯ Age:____ Mumps: ◯ Age:_____ Other: _____

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, please explain: _____

_____

_____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y N If Yes, Please list: _____

_____

Has your child ever been involved in a car accident? Y N If yes, please explain: _____

_____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize 180 Health Solutions - A Wellness Way Affiliate to administer care to my son/daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Relationship to Patient: _____ Date: _____