PEDIATRIC PATIENT HISTORY FORM

Welcome to Ager Chiropractic Wellness Center!
Please take a moment to fill out this form and sign the back.
Thanks! We will take GREAT care of you here!

Child's Name_____ Mother's Name_____
Date of Birth_____Age_____ Father's Name_____
Address_____City_____State___Zip_____
Phone Number_____SSN_____ Sex M or F Birth Weight_____
Current Weight_____ Email_____
Who referred you to our office?_____
Purpose of This Appointment_____
_____
Purpose of Last Visit to MD_____
Type of Birth: Normal/Vaginal _____ Forceps_____ Vacuum_____ C-section_____
Home_____Hospital_____ Labor time (hours) _____ Pushing time (minutes)_____
Gestational age at birth (weeks) _____
Problem during pregnancy?_____
_____
Problem with labor/delivery?_____
_____
APGAR Scores:_____ Present at birth? Jaundice(yellow)_____Cyanosis(blue)_____
Congenital Anomalies/Defect_____
Infant Feeding: Breast_____ Bottle_____ Formula_____
Quality of Sleep: Good_____ Fair_____ Poor_____
Immunization History: All on schedule _____Delayed schedule_____ None _____Other (specify on back)
Any childhood diseases?_____
Past or current use of antibiotics or other prescription medications? _____
Development History: At what age did the child…? Check here if all milestones achieved on time _____

Smile:	Stand:	Walk alone:	Crawl:	Hold object with hands:
Hold head up:	Sit alone:	Talk:	Follow object with eyes:	

Has this child ever suffered from?: (Circle all that apply)

Dizziness	Behavioral problems	Arm Problems	"Growing pains"
Diabetes	Backaches	Ruptures/hernias	Stomacheaches
Anemia	Headaches	Blood disorders	Chronic earaches
Poor appetite	Digestive disorders	Heart troubles	Cold/Flu
Bed wetting	Rheumatic fever	Diabetes/hypoglycemia	Allergies
Fainting	Hyperactivity	Paralysis	Constipation
Neck problems	Seizures	Broken bones	Diarrhea
Joint problems	Walking problems	Leg problems	Asthma

*Any other_____
Surgery_____
Medications_____
Accidents_____
Family History_____
Has your child ever been treated on emergency basis?: Y or N If so, why?_____

**If you would like for us to check insurance benefits, please provide us with your insurance card.

REASON FOR VISIT

THE REASON FOR THIS VISIT IS THE RESULT OF (PLEASE CIRCLE):
AUTO INJURY FALL SPORTS CHRONIC WELLNESS SPINAL CHECK OTHER
PLEASE DESCRIBE YOUR MAJOR COMPLAINT AND HOW IT HAPPENED:_____
_____
_____
DATE STARTED___/___/___ HAD BEFORE? YES NO PLEASE DESCRIBE:_____
_____
_____
IS THE CONDITION INTERFERING WITH (CHECK ALL THAT APPLY): SLEEP SCHOOL DAILY ROUTINE SPORTS

HEALTH HABITS

PLEASE CHECK ANY THE HABITS THAT YOUR CHILD HAS:

____JUNK FOOD	____HEALTHY FOODS	____BREAKFAST DAILY
____SODA/HIGH SUGAR DRINKS	____DIET DRINKS	____ADEQUATE WATER INTAKE
____HIGH ACTIVITY LEVEL/EXERCISE	____LOW ACTIVITY LEVEL/SEDENTARY	____HIGH IMPACT SPORTS

____EXCESSIVE TELEVISION/COMPUTER USE (AVERAGE HOURS PER DAY_____)
____EXCESSIVE HANDHELD VIDEOGAME USE (AVERAGE HOURS PER DAY_____)

PATIENT TRAUMA HISTORY

APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THE FIRST YEAR OF LIFE (I.E. BED, CHANGING TABLE, DOWN STAIRS, ECT.) WAS THIS THE CASE WITH YOUR CHILD? YES NO IF YES,EXPLAIN_____
_____
HAS YOUR CHILD EVER BEEN INVOLVED IN ANY HIGH-IMPACT SPORTS OR CONTACT-TYPE SPORTS (I.E. FOOTBALL, SOCCER, GYMNASTICS, HOCKEY, BASKETBALL, MARTIAL ART, ECT.)? YES NO IF YES, EXPLAIN_____

HAS YOUR CHILD EVER BEEN INVOLVED IN AN AUTOMOBLE ACCIDENT? YES NO DATE_____EXPLAIN_____
_____
ANY RESIDUAL HEALTH COMPLICATIONS RELATED TO ACCIDENT?_____
ANY ADDITIONAL FALLS, TRAUMAS, OR HEALTH RELATED ISSUES NOT YET LISTED?_____
_____

FAMILY HISTORY

PLEASE MARK FAMILY HISTORY OF THE BELOW CONDITONS USING THE FOLLOWING KEY:
M=MOTHER **F**=FATHER **S**=SIBLING **PG**=PATERNAL GRANDPARENT **MG**=MATERNAL GRANDPARENT

_____ALLERGIES	_____ASTHMA	_____CANCER	_____DIABETES
_____HEART CONDITION	_____HIGH BLOOD PRESSURE	_____MENTAL ILLNESS	
_____SCOLIOSIS	_____KIDNEY DISEASE	_____LIVER DISEASE	
_____DEPRESSION	_____STROKE	_____OVERWEIGHT/OBESITY	
_____SKIN CONDITIONS	_____LACK OF FOCUS	_____OTHER_____	

Consent to Treat a Minor

I hearby authorize Drs. Ager and Sonday and whomever they may designate as her assistants to administer treatment, as they deem necessary to my child, _____.
(child name)

Print name _____ **Relationship to patient** _____

Signature _____ **Date**_____