

Patient Name: _____ DOB: _____ Date: _____

PEDIATRIC HEALTH HISTORY FORM

1. Please describe any significant illnesses/difficulties/traumas during your pregnancy with this child: _____

2. Please check off all that apply to the birth of this child:

_____ Home birth _____ Hospital birth _____ Length of labor _____,

Medications used _____,

_____ Caesarean _____ Vaginal _____ Forceps _____ Vacuum _____ Manual assistance

3. Was your baby **breastfed**? _____ If yes, how long? _____

4. Has your child received ___ complete, ___ partial or ___ no vaccinations?

5. Any **sleeping problems**? _____

6. Please describe any **falls, stitches, fractures, car accidents, sports injuries or other traumas** that your child has experienced since birth:

7. Please tell us about any **health issues** that your child has had since birth:

8. Any known **food allergies**?

9. Please list any **medications** that your child is currently taking:

10. Please list any **supplements** that your child is currently taking:

11. Are there any **emotional stressors** in your child's life?

12. Please tell us **why you have brought your child for a chiropractic evaluation today**:

PLEASE USE BACK SIDE OF PAPER FOR MORE SPACE, IF NEEDED