# Winters Wellness Center-Michael A. Winters DC

## 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!

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Date: ________________________________Referred By: _____________________________________________

Child's Name:___________________________________________ Phone Number: ________________________

Address:____________________________________ City:__________________ State:_____ Zip:___________

Sex: M F Weight:_________ Height:________ S.S.#:___________________ Birth Date:_______________

Name of Parents/Guardians:___________________________________ Phone Number:______________________

Purpose for Contacting Us?______________________________________________________________________

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

_____________________________________________________________________________________________

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

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

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: ___________________________________________________________________________

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**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

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**Childhood Diseases:**

Chicken Pox: Y N Age:_____ Rubeola: Y N Age:_____ Whooping Cough: Y N Age:_____

Rubella: Y N Age:_____ Mumps: Y N Age:_____ Other: ________________________

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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: ___________________________________________

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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 **Your Office Name** 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: __________________________