PEDIATRIC MEMBER HEALTH HISTORY

Taylor Family Wellness Chiropractic
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Dear New Patient,
It is a 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 help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	WORK PHONE:
CELL PHONE:	DATE OF BIRTH:
AGE:	GENDER:
HEIGHT:	WEIGHT:
REFERRED BY:	

PREVIOUS CHIROPRACTOR: DATE OF LAST VISIT:
NAME OF PEDIATRICIAN: DATE OF LAST VISIT: REASON FOR VISIT: ARE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED ❑ Y ❑ N
NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: _____ LAST 6 MONTHS _____ LIFE
VACCINATION HISTORY:

INSTRUCTIONS: *Check any of the following conditions your child has suffered from in the past six months:*

❑ EAR INFECTIONS	❑ SCOLIOSIS	❑ CHRONIC COLDS
❑ HEADACHES	❑ COLIC	❑ GROWING/BACK PAINS
❑ TEMPER TANTRUMS	❑ SEIZURES	❑ ASTHMA/ALLERGIES
❑ DIGESTIVE PROBLEMS	❑ ADHD	❑ CAR ACCIDENT
❑ RECURING FEVERS	❑ BED WETTING	❑ OTHER_____

DEVELOPMENTAL HISTORY

IS/HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT SPORTS? (I.E. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC.) ❑ N ❑ Y LIST_____
HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT ❑ N ❑ Y LIST_____
HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS? ❑ N ❑ Y LIST_____
PRIOR SURGERY ❑ N ❑ Y LIST_____
MENARCHE: ❑ N ❑ Y AGE:_____

NAMES OF PARENTS/GUARDIANS:
PURPOSE FOR CONTACTING US?
OTHER DR'S SEEN FOR THIS CONDITION:
PRIOR TREATMENTS GIVEN FOR THIS CONDITION:
OTHER HEALTH CONCERNS:

TYPE OF BIRTH

Check all that apply		
❑ NORMAL VAGINAL	❑ EPIDURAL	❑ FORCEPS
❑ SUCTION	❑ BREECH	❑ CESAREAN
❑ HOME BIRTH	❑ HOSPITAL BIRTH	
BIRTH WEIGHT	BIRTH LENGTH	APGAR _____; _____

PRENATAL HISTORY

NAME OF OBSTETRICIAN/MIDWIFE:
COMPLICATIONS DURING PREGNANCY ❑ N ❑ Y LIST_____
ULTRASOUNDS DURING PREGNANCY ❑ N ❑ Y NUMBER_____
MEDICATIONS DURING PREGNANCY ❑ N ❑ Y LIST_____
CIGARETTE/ALCOHOL USE DURING PREGNANCY ❑ N ❑ Y

FEEDING HISTORY

BREAST FED: ❑ N ❑ Y HOW LONG?_____
FORMULA FED: ❑ N ❑ Y HOW LONG?_____ TYPE?_____

AUTHORIZATION FOR CARE FOR A MINOR:

I hereby authorize this office and Dr. Taylor to administer care to my son/daughter as she deems necessary. I understand that any and all care will be discussed with me prior to administration.

SIGNATURE:_____

DATE:_____