Nashville Spine, Sport & Family
Pediatric History Form

Today's Date: _____ Patient Name: _____

Address: _____
City State Zip

Birth Date: _____ Sex: Male Female Weight: _____ Height: _____

Referred by: _____

Parent/Guardian Name(s): _____

Primary Phone: _____ Secondary Phone: _____

Purpose for contacting us: _____

Other doctors seen for this: _____

Other health problems: _____

Check any of the following conditions your child has ever suffered from:

____ Ear Infections	____ Scoliosis	____ Seizures	____ ADHD
____ Chronic Colds	____ Bed Wetting	____ Headaches	____ Colic
____ Digestive Problems	____ Allergies	____ Asthma	____ Fevers
____ Temper Tantrums	____ Car Accident	____ Back/Neck Pain	

____ Other: _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total: _____

Do you feel they helped? Yes No Why? _____

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

During the past 6 months: _____ Total: _____

Do you feel they helped? Yes No Why? _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? Yes No List: _____

Ultrasounds during pregnancy? Yes No Number: _____

Medications during pregnancy/delivery? Yes No List: _____

Cigarette/Alcohol use during pregnancy? Yes No

Location of Birth: ____ Hospital ____ Birthing Center ____ Home
Birth Intervention: ____ Forceps ____ Vacuum Extraction ____ C-Section (Emergency/Planned)
Complications during delivery? Yes No List: _____
Genetic disorders/disabilities? Yes No List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:
Breast Fed: Yes No How long? _____ Formula Fed: Yes No How long? _____
Introduced to solids at: _____ months, Cow's milk at: _____ months
Food/Juice allergies or intolerances: _____
_____

Developmental History: During the following times your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic.

_____ Respond to sound
_____ Respond to visual stimuli
_____ Hold head up
_____ Sit up
_____ Cross crawl
_____ Stand alone
_____ Walk alone

In the first year, did your child fall from a high place (i.e. bed, changing table, down stairs, etc.)? Yes No

List any sports your child has participated in: _____
_____

Has your child ever been seen on an emergency basis? Yes No List: _____
_____

Prior surgeries: Yes No List: _____

Childhood Diseases: (please note age)

Chicken Pox: _____ Mumps: _____ Rubella: _____
Whooping Cough: _____ Measles: _____ Other: _____

We are here to serve you and encourage you to ask questions. Your participation is vital and will help determine your results.

Authorization for Care of a Minor

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Date: _____