

JUDSON FAMILY CHIROPRACTIC
PEDIATRIC HEALTH HISTORY
WELCOME TO OUR FAMILY!

Date _____
Name _____ Patient # _____
Address _____ City/State/Zip _____
Home Phone # _____ Social Security Number _____
Date of Birth _____ Referred by: _____
Hobbies _____

Name of Previous Chiropractors _____ When was your last visit? _____
For how long were you receiving Chiropractic adjustments? _____

Reason for coming in _____

What accidents have you had (ex. Bicycle, car, motorcycle, sports, slips/falls) at work or at home (include dates) _____

Were you ever knocked unconscious? _____
What fractures or broken bones have you had? (include dates) _____

PRENATAL HISTORY:

Name of Obstetrician/Midwife: _____
Complications during pregnancy? No Yes, List: _____
Ultrasounds During Pregnancy? No Yes, Number: _____
Medications during Pregnancy / Delivery? No Yes, List: _____
Cigarette / Alcohol Use During Pregnancy? No Yes
Location of Birth: Hospital _____ Birthing Center _____ Home _____
Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Ceasarian Section: Emergency or Planned
Any complications after your birth? _____

DEVELOPMENTAL HISTORY:

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?

_____ No _____ Yes

Is / has your child been involved in any high impact or contact type sports? _____

Has your child ever been involved in an Automobile Accident? _____

Has your child been seen on an Emergency Basis? _____

Has your child had prior surgery? _____

CHILDHOOD DISEASES:

Chicken Pox	n / y, Age _____	Mumps	n / y, Age _____
Rubella	n / y, Age _____	Whooping Cough	n / y, Age _____
Rubeola	n / y, Age _____	Other	n / y, Age _____

FINANCIAL INFORMATION:

Who is responsible for this account? _____

What method of payment will you be using? Insurance Cash Check MC/Visa/Discover/AmEx Other

Name of Insurance Company _____ Policy # _____

Insured's Date of Birth _____

Do you have secondary insurance? () Yes () No

Name of Insurance Company _____ Policy # _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Dr.'s Notes:
