



AAC Family Wellness Centers
402 Rowland Street
Ballston Spa, NY 12020

PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our family of happy and healthy Chiropractic kids. 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 coaching you to build better health for you and your family.

Name: _____ Parents SS# _____
 Address: _____ City: _____
 State: _____ Zip: _____ Home Phone: _____
 Name/s of Parents/Guardians: _____
 Work Phone: _____
 Birth Date: _____ Sex: M F Weight: _____ Height: _____

Purpose for contacting us? _____
 Other doctors seen for this condition: _____
 Prior treatments: _____
 Other known health problems: _____

Check any of the following conditions your child has suffered during the past 6 months:

Ear infections	Seizures	Headaches
Asthma/Allergies	ADD/ADHD	Colic
Growing/Back pain	Car accident	Scoliosis
Digestive problems	Recurring fevers	Chronic colds
Bed wetting	Temper tantrums	Other _____

Family History: _____

Previous Chiropractor: _____
 Date of last visit: _____ Reason: _____

Name of Pediatrician: _____ Last visit date: _____
 Reason: _____

Number of doses of antibiotics your child has taken:
 During the past 6 months: _____ Total during his/her lifetime: _____

Number of doses of prescription medications your child has taken:
 During the past 6 months: _____ Total during his/her lifetime: _____
 List: _____

PRENATAL HISTORY:

Name of Obstetrician/Midwife: _____

Complications during pregnancy: Yes No Describe: _____

Ultrasounds during pregnancy: Yes No Number: _____

Medications during pregnancy/delivery: Yes No List: _____

Cigarette/Alcohol use during pregnancy: Yes No

Location of birth (circle): Hospital Birthing Center Home Other: _____

Intervention? Forceps Vacuum Extraction C section: Emergency or Planned?

FEEDING HISTORY:

Breast-fed? Yes No How long? _____

Formula fed? Yes No How long? _____ Type: _____

Introduced to solids at _____ months. Introduced to cow's milk at _____ months.

Known food/juice allergies or intolerances? Yes No List: _____

DEVELOPMENTAL HISTORY:

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

Respond to stimuli _____

Respond to visual stimuli _____

Hold head up _____

Sit up _____

Cross crawl _____

Stand-alone _____

Walk alone _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (a bed, changing table, stairs, etc). Was this the case with your child? Yes No

Is/has your child been involved in any high impact or contact type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Yes No List: _____

Has your child ever been involved in a motor vehicle accident? Yes No Describe: _____

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

Other traumas not described above: _____

Prior surgery: _____

Menarche: Yes No Age _____

CHILDHOOD DISEASES:

Chicken Pox Yes No Age _____

Rubella Yes No Age _____

Rubeola Yes No Age _____

Mumps Yes No Age _____

Whooping cough Yes No Age _____

Other _____ Age _____

I hereby authorize this office and its Doctors to administer care to my son/daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for all fees and charges by this office.

Signed Parent/Guardian _____ Date: _____