Miranda Chiropractic

PEDIATRIC HISTORY

It is a pleasure to welcome you to our family of chiropractic patients. Please complete the following information for us. We look forward to working with you to build better health for your family.

Patient name:_____SSN:_____

Address:_____City:_____

State:_____Zip:_____Home Phone:_____

Birth date:_____/_____/_____Sex:_____Weight:_____Height:_____

Name of parents/guardian:_____

Purpose for contacting us:_____

Other doctors seen for this condition:_____

Approximate dates seen:_____

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

____ADHD	____Asthma	____Allergies	____Bed Wetting
____Car Accident	____Colic	____Chronic Colds	____Digestive Problems
____Ear Infection	____Growing Pains	____Headaches	____Recurring Fevers
____Seizures	____Temper Tantrums		

Previous chiropractor:_____

Date of last visit:_____Reason for visit:_____

Name of pediatrician:_____

Date of last visit:_____Reason for visit:_____

Number of doses of antibiotics your child has taken

During the last 6 months:_____Total during his/her lifetime:_____

Number of doses of OTHER PRESCRIPTION MEDICATIONS your child has taken:

During the last 6 months:_____Total during his/her lifetime:_____

Please list:_____

Vaccination history:_____

Name of obstetrician/midwife:_____

Complications during pregnancy:_____

Ultrasounds during pregnancy (please circle): YES NO Number of ultrasounds:_____

Medications taken during pregnancy (please list):_____

Cigarettes/alcohol use during pregnancy (please circle): YES NO

Location of birth: ____Hospital ____Birthing center ____Home