Farrar Family Chiropractic
A Health and Wellness Center

Pediatric History Form

Date_____ Referred By_____
Patient Name_____ Phone Number_____
Address_____
City_____State_____Zip_____
Birth Date_____Sex_____Weight_____Height_____SS#_____
Names of Parents/Guardians_____
Purpose for contacting us?_____
Other doctors seen for this condition_____
Treatment_____

Check any of the following that pertains to your child:

☐ Ear Infections	☐ Digestive Problems	☐ ADHD	☐ Temper Tantrums
☐ Asthma	☐ Bed Wetting	☐ Auto Accident	☐ Headaches
☐ Allergies	☐ Seizures	☐ A Fall	☐ Chronic Colds
☐ Colic	☐ Recurring Fevers	☐ Traumatic Birth	☐ Adverse vaccination reaction
☐ Scoliosis	☐ Constipation	☐ Diarrhea	

☐ Other_____
Family History_____
_____
Name of Pediatrician_____ Date of last visit_____
Reason_____Treatment_____
Number of doses of antibiotics your child has taken:
1) In last 6 months:_____
2) Total during his/her life:_____
Number of doses of other prescription medications your child has taken:
1) During last 6 months:_____
2) Total during his/her life:_____
Vaccination history:_____

Feeding History:
☐ Breast-fed If yes, how long?_____ ☐ FormulaIf yes, how long?_____
Introduced solids at _____ months. Cow's milk at _____ months.

Prenatal History:
☐ Complications during pregnancy? Explain_____
☐ Ultrasounds during pregnancy? How many?_____
☐ Medications during pregnancy/delivery? List them_____
☐ Cigarette/alcohol use during pregnancy? Frequency_____
Location of Birth ☐ Hospital ☐ Home ☐ Other_____
Birth intervention ☐ Forceps ☐ Vacuum Extraction ☐ C-section
Delivery complications? ☐ No ☐ Yes_____
Birth Weight_____Birth Length_____APGAR Scores_____

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Pediatric History Form Continued

Childhood Diseases:

☐ Chicken Pox Age:_____ ☐ Rubeola Age:_____ ☐ Whooping Cough Age:_____
☐ Rubella Age:_____ ☐ Mumps Age:_____ ☐ Other_____

Developmental History:

At what age was your child able to:

Respond to sound _____ Crawl _____
Respond to visual stimuli _____ Stand Alone _____
Hold head up _____ Walk Alone _____
Sit _____

Has your child ever been involved in a car accident? ☐ No ☐ Yes (List)_____
Has your child ever fallen? ☐ No ☐ Yes (List)_____
Prior surgery? ☐ No ☐ Yes (List)_____

I hereby authorize Farrar Family Chiropractic to administer care to my son/daughter.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed_____Date_____
Relationship to Patient_____