Fischer Health & Rehab

PEDIATRIC HISTORY FORM

413 King George Road, Suite 205 • Basking Ridge, NJ 07920 • Phone: 908.903.1901 • Fax: 908.903.1902

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. 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 working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Parents Cell Phone: _____

Sex: _____ Weight: _____ Height: _____ How did you find out about us: _____

Names of Parents / Guardians: _____

Purpose For Contacting Us? _____

Other Doctors Seen for this Condition: _____ N _____ Y, Doctors' Name and Prior Treatments: _____

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ 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 Six Months: _____ , Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken: _____

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Any Adverse Reactions? _____ N _____Y Please Explain: _____

Prenatal History:

Name of Obstetrician / Midwife:

Complications During Pregnancy? _____ N _____ Y, List: _____

Ultrasounds During Pregnancy? _____ N _____Y, Number: _____

Medications During Pregnancy / Delivery? _____ N _____Y, List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____Y

Location of Birth: _____Hospital _____Birthing Center _____ Home

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Birth Intervention: ____ Forceps ____Vacuum Extraction
____ Caesarian Section, Emergency or Planned (Circle)
Complications During Delivery? ____ N ____Y, List: _____
Genetic Disorders or Disabilities: ____ N ____Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: ____ N ____Y, How Long: _____
Formula Fed: ____ N ____Y, How Long: _____ Type: _____
Introduced to Solids at: _____ Months, Cows' Milk at _____ Months
Food / Juice Allergies or Intolerances: ____ N ____ Y, List: _____

Developmental History:

During the following time 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 Sound	____ Cross Crawl
____ Respond to Visual	____ Stand Alone
____ Hold Head Up	____ Walk Alone
____ Sit Up	

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? ____ N ____ Y
Is / has your child been involved in any high impact or contact type sports: (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ____ N ____ Y, List: _____
Has Your Child Ever Been involved in a Car Accident? ____ N ____Y, List: _____
Has Your Child Been Seen on an Emergence Basis? ____ N ____Y, List: _____
Other Traumas Not Described Above? ____ N ____ Y, List: _____
Prior Surgery: ____ N ____ Y, List: _____
Menarche: ____ N ____Y, Age: _____

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: ____

WE ARE HERE TO SERVE YOU , AND ENCOURAGE YOU TO ASK QUESTIONS,

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and it's Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____
Signed: _____ Witnessed: _____ Date: ____ / ____ / ____