PEDIATRIC PATIENT HISTORY

Child's Name: _____

SS#: _____

DOB: _____ Grade In School: _____ Sex: _____

Home Phone: ( ) _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Mother's Name: _____

Cell/Work Phone: _____ / _____

Father's Name: _____

Cell/Work Phone: _____ / _____

Referred By: _____

Purpose of this appointment:

_____

_____

_____

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)

Did you experience any of the following during your pregnancy:

- ☐ Severe viral infection during the first trimester
- ☐ Alcohol consumption and/or drug use
- ☐ Breech position during pregnancy
- ☐ Radiation exposure
- ☐ Accident or Infections
- ☐ Hypertension (high blood pressure)
- ☐ Smoking
- ☐ Toxoplasmosis
- ☐ Severe stress
- ☐ Pre-eclampsia
- ☐ Uncontrolled Diabetes
- ☐ Toxemia

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- ☐ Hospital birth
- ☐ Birthing center
- ☐ Long and/or difficult labor
- ☐ Placenta previa
- ☐ Forceps or suction cup used
- ☐ Fetal distress
- ☐ Elective c-section
- ☐ The child was a "blue baby"
- ☐ Home birth
- ☐ The labor was induced
- ☐ The delivery was rapid
- ☐ Breech birth
- ☐ Cord around the neck
- ☐ Emergency c-section
- ☐ The child was premature (2+ weeks)

Comments: _____

_____

_____

_____

Newborn History

Did the child experience any of the following as a newborn:

- ☐ Required resuscitation/oxygen
- ☐ Prolonged jaundice
- ☐ Poor sleeper
- ☐ Breast fed
- ☐ Colic
- ☐ Distorted skull
- ☐ Difficulty latching/sucking
- ☐ Formula fed
- ☐ Bottle fed
- ☐ Immunizations in hospital... If yes, specify vaccine: _____

Weight at birth: _____ Length at birth: _____

Health History

Has your child ever experienced the following or been diagnosed as having any of the following

- ☐ Illnesses accompanied by a high fever
- ☐ Frequent headaches
- ☐ Seizures/Convulsions
- ☐ Chronic ear infections/earaches
- ☐ Trouble with bladder control (enuresis)
- ☐ Head injury
- ☐ Serious illness
- ☐ Epilepsy
- ☐ Meningitis
- ☐ Allergies to foods
- ☐ Environmental allergies
- ☐ Chemical insensitivities
- ☐ Undergone any surgeries
- ☐ Neck or back problems
- ☐ Adverse reaction to any vaccinations (even if mild)
- ☐ Dizziness
- ☐ Diabetes
- ☐ Hypoglycemia (low blood sugar)
- ☐ Fainting
- ☐ High blood pressure
- ☐ Serious fall(s) or repetitive falls
- ☐ Heart disease
- ☐ Asthma
- ☐ Sinus problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestive disorders
- ☐ Rheumatic Fever
- ☐ Joint or muscle problems

If yes, please explain:

Developmental History

Does or did your child have any of the following:

- ☐ Difficulty with crawling (on all fours)
- ☐ Appears clumsy
- ☐ Difficulty or awkward with walking/running
- ☐ Did not crawl on all fours
- ☐ Difficulty using utensils
- ☐ Poor hand-eye coordination

At what age did your child start to walk unassisted: _____

Alicia Bolzenius D.C.
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Consent to Treat a Minor Child

I hereby authorize Dr. Alicia Bolzenius and whomever she may designate as her assistants to administer treatment, as she so deems necessary to _____ _____ this _____ day of _____.

Signature of Parent or Guardian: _____

Witnessed: _____

Date: _____