GREEN CHIROPRACTIC & WELLNESS, LLC
22780 Three Notch Road, Lexington Park, MD 20653
Phone: 301-737-0662 Fax: 301-737-0675

PEDIATRIC HISTORY FORM (Age 5 and Under)

Patient Name: _____
Birth Date: _____ / _____ / _____
Age: _____ Sex: _____ Weight: _____ Height: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Names of Parents / Guardians: _____
Parent's Work Phone: _____
Referred By: _____
Purpose for today's visit? _____
Other Doctors Seen for this Condition: _____
Prior Treatments: _____
Check any of conditions your child has suffered from during the past 6 months:

- ☐ Ear Infections
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches / Neck Pain
- ☐ Back Pain
- ☐ Growing Pain / Leg Pains

Other Symptoms, conditions or diagnoses:
_____
_____
_____

Family History:

Previous Chiropractor: _____ Last Visit: ___ / ___ / ___
Reason: _____
Name of Pediatrician: _____ Last Visit: ___ / ___ / ____
Reason: _____
Number of doses of Antibiotics your child has taken during:
The past 6 months: _____ Lifetime: _____

Prenatal History:

Name of Obstetrician / Midwife: _____
During pregnancy did you:

- Have Complications? ☐ N ☐ Y
- Take Medications? ☐ N ☐ Y
- Smoke Cigarette? ☐ N ☐ Y
- Consume Alcohol? ☐ N ☐ Y

If yes to any answer, please explain:
_____
_____
_____

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Location of Birth:
☐ Hospital ☐ Birthing Center ☐ Home
Birth Intervention:
☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section: ☐ Emergency ☐ Planned
Complications During Delivery? ☐ N ☐ Y List _____
Genetic Disorders or Disabilities? ☐ N ☐ Y List _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____
Vaccination History: ☐ Uneventful ☐ Complications
List: _____

Feeding History:

Breast Fed: ☐ N ☐ Y… How Long? _____
Formula Fed: ☐ N ☐ Y… How Long? _____ Type _____
Introduced to:
Solids at _____
Cow's Milk at _____
Food / Environmental Allergies or Intolerances: ☐ N ☐ Y
List _____
Childhood Diseases:

- ☐ Chicken Pox : Age _____
- ☐ Rubella: Age _____
- ☐ Mumps : Age _____
- ☐ Whooping Cough : Age _____
- ☐ RSV
- ☐ Other

_____
_____

Developmental History:

At what age was your child able to:

- Hold Head Up _____
- Sit Up _____
- Cross Crawl _____
- Stand Alone _____
- Walk Alone _____

During their first year of life did they fall from a high location? ☐ N ☐ Y
If yes, describe:

_____

Is or has your child been involved in:

- Sports? ☐ N ☐ Y
- Traumas? ☐ N ☐ Y
- Prior Surgery: ☐ N ☐ Y
- Medication Usage: ☐ N ☐ Y

If yes, please list:

_____
_____
_____
_____