Whom may we thank for refferring you to our office? ______________________

PEDIATRIC HEALTH HISTORY FORM

180° CHIROPRACTIC & WELLNESS CENTER

Dr. Ben Sweeney Dr. /Joseph Gebhardt
4091 Mallory Lane Ste. 114
Franklin, TN 37067

Today's Date ________/________/_____________

Name_______________________________ Date of Birth _____/_____/______ Social Security # ________-______-__________

Address ______________________________________ City _____________________ State _______ Zip ___________________

Phone (Home) ________________________ Mothers mobile: ______________________Fathers mobile: ___________________

Mother_________________________ DOB_____/_____/________Father _______________________DOB_____/_____/_______

Pediatrician/Family MD __________________________City & State ___________________________ Last Visit: ____/____/____

Purpose of last visit ____

Birth Height: _______ Birth Weight: _______ Current Height: _______ Current Weight: _______ Age: _______

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? ____

Insurance Company ____

PREGNANCY HISTORY:

Third Trimester Presentation: ______Vertex ______Breech ______Transverse ______Face/Brow

Type of Birth: ______Normal Vaginal ______Forceps ______Cesarean ______Suction Cap or Vacuum

Location: ______Home _______Hospital ________Birthing Center _______Other:____________________

Problems during Pregnancy: ____

Problems during Labor/Delivery: ____

Was there presence of: ______Jaundice? (Yellow) ________Cyanosis? (Blue) ________Congenital Anomalies/Defects?

*If yes, please explain*____

INFANT HISTORY:

Infant feeding: ______Breast ______Bottle If Bottle; which Formula? __________________________________

Number of Hours sleep per night __________ Quality of Sleep: ______Good ______Fair ______Poor

List all **IMMUNIZATIONS** you child has had**:** ____

Has your child ever been treated at the emergency room? ________ If yes; please explain _______________________________

Has your child ever been hospitalized? _________ If yes; please explain ____

Has your child ever had any Surgeries? ________ If yes; please explain ____

Is your child currently on any medication? ________ If yes; please list: ____

AT WHAT AGE DID THE CHILD:

Respond to sound_________ Follow an object with his/her eyes_________ Hold heel up________
Sit Alone_________ Crawl________ Stand_________ Walk alone_________

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox_________ Mumps_________ Measles_________ Rubella________
Whooping Cough_________ Other: ____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to____________________
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to____________________
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to____________________
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _______________________
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _______________________

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: _______________________

Has your child ever sustained an injury playing organized sports? _______ If yes; please explain___________________________

____

Has your child ever sustained an injury in an auto accident? _______ if yes; please explain_________________________________

____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness _____Check-up _____Other: _______________________

_____Pain/Discomfort; explain____

_____Injury; explain____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/______ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? ____
3. Any **bowel or bladder** problems since this problem began?: No Yes *(Describe)*:_____________________________
4. Any **medication taken** for this problem? No Yes: ____
5. Have you seen any **other doctors** for this problem? No Yes: ____
6. How is this problem **NOW:** ☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On & Off

I understand that I am directly and fully responsible to 180°Chiropractic & Wellness Center for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report and X-Rays upon request.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

________________________________ ________________________________

Parent's or Legal Guardian's Signature Date