Koelling Family Chiropractic
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605 Nichols • Fulton, MO 65251 • (573) 642-2273

Pediatric Health History

Child's Name:____Date:________________Account#:____________

Address:____City_______________________________________

Child's SS#______________________________Family Email Address:________________________________

Purpose of this appointment:____

Mother's Name:___________________________________ Phone#:(H)_______________(W)_______________

Employer:____ Occupation:___________________________________

Father's Name:___________________________________ Phone#:(H)_______________(W)_______________

Employer:____ Occupation:___________________________________

Legal Guardian:__________________________________ Relationship to child:________________________

Age (years)_______(months)_______ Date of Birth___/____/____ Sex: Male Female

Siblings and ages:____

Birth Weight:_________ Birth Length______ Present Weight:________ Present Length/ Height:_________

Was the birth: normal vaginal cesarean breech forceps vacuum extraction

home birth birthing center______________________ hospital________________________

Pregnancy problems:____

Labor or Delivery problems:____

Congenital defects/ anomalies:_____________________________________APGAR scores:________________

Was there present at birth: meconium (black/green infant feces) cyanosis (blue/ lack of oxygen) jaundice (yellow)

Obstetrician/ Midwife:________________________________Address:____________________________________

Pediatrician/ Family MD:_____________________________Address:____________________________________

Has this child had vaccinations: Yes No; If so, please list dates:

Hep B__________ OPV__________ DTP__________ MMR__________ HIB__________ VAR__________

Other vaccinations:____

Has this child had any of the following childhood "diseases;" if so, please list dates:

Measles_____________ Chicken Pox____________ Whooping Cough____________ Mumps_____________
Other____

Date and purpose of last Medical Doctor visit:____

Has this child been treated for an emergency? Yes No; Please describe:__________________________

____

Please turn over and complete the other side.

Surgeries:____

Medications:____

if antibiotics, how many rounds/ dosages total since childbirth:____________________

Accidents:____

Allergies	Colic	"Growing pains"	Orthopedic problem(s)
Anemia	Constipation	Headaches	Paralysis
Arm problems	Convulsions	Heart trouble	Poor appetite
Arthritis	Diabetes	Hyperactivity	Rheumatic fever
Asthma	Diarrhea	Hypertension	Ruptures/ hernias
Backaches	Digestion problems	Joint problems	Sinus trouble
Bed wetting	Dizziness	Leg problems	Sugar levels (high/ low)
Behavior problems	Earaches	Muscle jerking	Tuberculosis
Broken bones	Ear infections	Neck problems	Walking problems
Colds/ Flu	Fainting	Neuritis	

Has this child ever suffered with any of the following:

Overall, how would you rate the health of this child since birth:____________________

____

Is there anything else we should know about this child?____________________

____

Diet:____

PERSONAL INJURY ONLY:

Was this child injured in an automobile accident? Yes No; Please explain:

____

Was this child riding in a car seat? Yes No; If no, please explain:

____

Was this child in a booster seat? Yes No

Was the car seat/ booster seat in the FRONT or the REAR seat (LEFT / CENTER / RIGHT) facing FORWARD or BACKWARD?

Was this child struck by an air bag? Yes No

Was the vehicle struck from the REAR/ FRONT/ LEFT/ RIGHT side?

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

____

Signature of Parent/ Legal Guardian Date