DR. CHRISSY GRAHAM

PEDIATRIC HISTORY FORM

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

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? ____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other *(please explain)* ______________________________________

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 ANY OF THESE?

☐ 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 hereby authorize this office and Dr. Chrissy Graham to administer care, as she so deems necessary to my son/daughter.

Printed Name_______________________________ Date _________________

Signature ____