Dr. Barbara Jennings
Natural Health In Real Life

Dr. Barbara Jennings at Health Summit Wellness
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CONFIDENTIAL PEDIATRIC HISTORY FORM

GENERAL INFORMATION

Date: Referred by:

Child's Name: _____ Phone # (h) _____ (c) _____

Address: _____

_____ Email Address _____

Height: _____ Weight: _____ Sex: M F S.S.#:_____ Date of Birth: _____

Name of Parents/Guardians: _____

Phone # (h) _____ (c) _____ Purpose for Contacting Us? _____

Other Doctors seen for this condition: Yes ____ No ____ If yes, please list doctor's name and prior treatments.

_____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear infections	☐ Bed Wetting	☐ Recurring Fevers	☐ Other
☐ Asthma/Allergies	☐ Seizures	☐ Temper Tantrums	_____
☐ Colic	☐ ADHD	☐ Headaches	_____
☐ Scoliosis	☐ Auto Accident	☐ Growing/Back pains	
☐ Digestive problems	☐ Chronic Colds		

Family History: _____

Previous Chiropractor: _____ Date of Last Visit: _____

Reason For Visiting: _____

Were you satisfied? Yes ____ No ____

Why? _____

Previous/Current Pediatrician: _____ Date of Last Visit: _____

Reason for Visiting: _____

Number of doses of antibiotics your child has taken:

a) During the past six months: _____ b) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:

a) During the past six months: _____

b) Total during his/her life: _____

Vaccination History: _____

_____

Feeding History

Breast Fed: Yes No If yes, how long? _____ Formula: Yes No If yes, how long? _____

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances: Y N

If Yes, please list: _____ Other allergies or tolerances: Y N

If Yes, please list: _____

Number of Hours Sleeping per Night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Prenatal History

Name of obstetrician/midwife: _____ Pediatrician/Family MD: _____

Birth intervention: Forceps _____ Vacuum Extraction _____ Caesarian Section _____

Emergency or Planned? _____ Ultrasounds during pregnancy? Yes No If yes, how many? _____

Medications during pregnancy/delivery? Yes No If yes, how many? _____

Cigarette/alcohol use during pregnancy? Yes No

Childhood Diseases

Chicken Pox: Yes No Age: _____ Rubeola: Yes No Age: _____ Whooping Cough: Yes No Age: _____

Rubella: Yes No Age: _____ Mumps: Yes No Age: _____ Other: _____

According to the national Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? Yes No If yes, please explain:

_____

_____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Yes No If yes, please list:

_____

_____

Has your child ever been involved in a car accident? Yes No If yes, please explain:

_____

_____

_____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Health Summit Chiropractic to administer care to my son/daughter, as they deem necessary. I clearly understand that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Relationship to Patient:_____

Date: _____