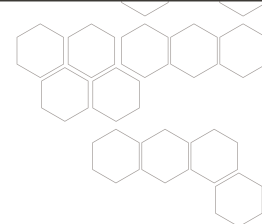


THE
WELLNESS
WAY



CONFIDENTIAL PEDIATRIC HISTORY FORM

It is our pleasure to welcome you to our family of happy and healthy Wellness Way patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Date: _____ Referred By: _____

Child's Name: _____ Phone Number: _____

Do you have other immediate household family members who are patients here? Yes No

If yes, please list them _____

Address _____ City _____ State _____ Zip _____

Sex Male Female Weight _____ Height _____ Birth Date _____

Name of Parents/Guardians _____ Phone Number _____

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:

- | | | | |
|--|--|--|--|
| <input type="radio"/> Ear Infections | <input type="radio"/> Digestive Problems | <input type="radio"/> Auto Accident | <input type="radio"/> Headaches |
| <input type="radio"/> Asthma/Allergies | <input type="radio"/> Bed Wetting | <input type="radio"/> Chronic Colds | <input type="radio"/> Growing/Back Pains |
| <input type="radio"/> Colic | <input type="radio"/> Seizures | <input type="radio"/> Recurring Fevers | <input type="radio"/> Other: _____ |
| <input type="radio"/> Scoliosis | <input type="radio"/> ADHD | <input type="radio"/> Temper Tantrums | _____ |

Family History: _____

Previous Chiropractor: _____ Date of Last Visit: _____ Reason: _____

Were you satisfied? Yes No Why? _____

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

Number of doses of antibiotics your child has taken:

a) During the past six months: _____

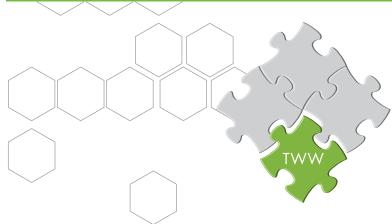
b) Total during his/her life: _____

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

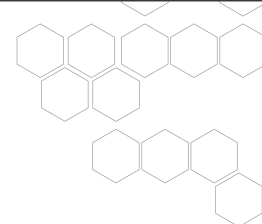
a) During the past six months: _____

b) Total during his/her life: _____

Vaccination History: _____



THE WELLNESS WAY



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: Yes No If Yes, Please List _____

Other allergies or tolerances: Yes No 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, please list them: _____

Cigarette/alcohol use during pregnancy? Yes No How much and how often? _____

Childhood Infections

Chicken Pox: Yes No Age: _____ Measles (Rubeola) Yes No Age: _____ Whooping Cough: Yes No Age: _____

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

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? Y N – 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 BOTH YOU AND YOUR CHILD TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Signature

Relationship to Patient

Date