THE WELLNESS WAY

The Wellness Way - Eau Claire
4410 Golf Terrace, Suite 120, Eau Claire, WI 54701
thewellnessway.com

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:

○Ear Infections	○Digestive Problems	○Auto Accident	○Headaches
○Asthma/Allergies	○Bed Wetting	○Chronic Colds	○Growing/Back Pains
○Colic	○Seizures	○Recurring Fevers	○Other: _____
○Scoliosis	○ADHD	○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:_____

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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**