

**Timothy Jameson, Doctor of Chiropractic
Pediatric History Form**

Dear parent or guardian,

We are looking forward to determining if chiropractic is indicated for your child to improve his/her health and wellness. To help us understand your child's condition and state of health, please complete the following information to the best of your knowledge. If you don't know the answers, just leave them blank.

Child's Name _____ Nickname? _____

Address _____ City _____

State _____ Zip _____

Your Home Phone _____ Cell Phone _____ Office _____

Best way to contact you? Home, cell, work (please circle)

Child's Birth Date _____ Sex _____ Current Weight _____ Height _____

Who referred you to our office? _____

Names of parents/guardians _____

Parent's or Guardian's Email address _____

Reason for child's visit to our office: What is your major concern(s) about your child's health?

Has your child undergone treatment with any other doctors or health care providers, other than "well care" visits? N Y If yes, please explain doctors and treatments rendered below.

Check any of the following conditions that may pertain to your child

Ear infections Scoliosis Seizures Chronic colds Headaches
 Asthma/Allergies Digestive ADHD Recurring fevers Growing pains
 Colic Bed Wetting Car Accident Temper Tantrums Other _____

Do any health problems run in your family? (i.e. genetic, diabetes, cancer, high blood pressure. Etc.)

Previous Chiropractor? (Y) (N) Name and location _____

Pediatrician Name and location _____

Are you satisfied with the pediatrician's care of your child? Y N If no, Please explain

Number of doses of antibiotics your child has had since birth _____

Please name all prescription medicines your child is taking (even other-the-counter)
