PEDIATRIC **HISTORY FORM**

INTERNAL USE ONLY

// COMPLETE: *Patient Information*

Patient Name _____ DOB: ___/___/___

SSN #: _____ Weight _____ lbs. / oz. Height _____ ft. / in. Sex ☐ F ☐ M

// COMPLETE: *Parent / Guardian Information*

Parent / Guardian Name _____ Phone _____

Parent / Guardian Name _____ Phone _____

Drivers License # _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

// Pediatrician Information *List all information below.*

Name of Pediatrician _____ Date of last visit ___/___/___

Reason for last visit _____

How were you referred to our office?

☐ Friend / Family Member If so, what is their name? _____

☐ Healthcare Provider If so, what is their name? _____

☐ Walk-In ☐ Online Search ☐ Social Media ☐ Other _____

// COMPLETE: *Insurance Information*

Insurance Company _____ Relationship to Insured _____

POLICY HOLDER INFORMATION

Name _____ DOB ___/___/___ SSN: _____

Occupation _____ Employer _____

BETTER BRAIN & BODY
CHARLOTTE'S BRAIN CENTER

// COMPLETE: Conditions Suffered by Child *(check all that apply)*

- ☐ Ear Infections
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Growing Pains
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Back Pains
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Other _____
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums

// Vaccination History *List all your child has had.*

1. _____ **2.** _____ **3.** _____ **4.** _____

5. _____ **6.** _____ **7.** _____ **8.** _____

During past 6 months? _____ Total During his / her lifetime? _____

// Prenatal History *List all information below.*

Name of Obstetrician / Midwife _____

Birth Intervention: ☐ Planned ☐ Forceps ☐ Vaccuum Extraction ☐ Cesarean Section ☐ Emergency

Complications during pregnancy? ☐ No ☐ Yes. If yes, list: _____

Medications during preganancy? ☐ No ☐ Yes. If yes, list: _____

Complications during delivery? ☐ No ☐ Yes. If yes, list: _____

Medications during delivery? ☐ No ☐ Yes. If yes, list: _____

// Feeding History *List all information below.*

Did you breast feed? ☐ No ☐ Yes. If yes, how long? _____

Did you formula feed? ☐ No ☐ Yes. If yes, how long? _____

What type / brand? _____ Introduced to cow's milk? ☐ No ☐ Yes

Food / Juice Allergies / Intolerances? ☐ No ☐ Yes. If yes, list: _____

According to the National Safety Council, approximately 50% of children fall head first from a high elevation during their first year of life (i.e.: a bed, changing table, etc.). Has this happened with your child? ☐ No ☐ Yes

// AUTHORIZATION FOR CARE OF MINOR *Please sign below.*

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for the payment of all fees charged by this office.

GUARDIAN NAME: _____ **DATE:** ___/___/___

GUARDIAN SIGNATURE: _____