Masterson Chiropractic Clinic
725 E. Market St.
Warsaw, IN 46580
Pediatric History (0-12 Years)

Patient Name_________________________________Birthday________________

Parent or Guardian____

List all therapies undergone for this complaint (including medication)

____

____

Duration of pregnancy____________weeks

Pregnancy normal Yes No

List any complications of delivery____

____

List any medications taken

During pregnancy____

During delivery____

Was the infant alert and responsive within 12 hours of birth Yes No If no please explain____

____

Breastfed Yes No How many months breastfed ____________

Formula given Yes No At what age started __________ Number of months given formula_______________

Intolerances/allergies____

____

Does the child's social behavior appear normal for age Yes No

If no please explain____

____

Has your child ever experienced any of the following:

Y N Chickenpox (age_____)

Y N Mumps (age_____)

Y N Measles (age_____)

Y N Rubella (age_____)

Y N Rubeola (age_____)

Y N Whooping Cough (age_____)

Y N Hyperactivity (age_____)

Y N Attention Deficit Disorder (age diagnosed_____)

Y N Learning Disability (age diagnosed_____)

Y N Digestive problems (age began_____)

Y N Hypoglycemia (age diagnosed_____)

Y N Diabetes (age diagnosed______)

Y N Bed-wetting (resolved Y N)

Y N Nosebleeds (resolved Y N)

Y N Asthma (age began_____)

Y N Headaches (age began_____)

Y N Colds/Flu

Y N HIV (age diagnosed_____)

Y N Hay fever (age began_____)

Y N Arm or Leg Pain/Tingling (age began_____)

Y N Arthritis (age began _____)

Y N Poor posture

Y N Scoliosis

Y N Drug addiction (when began______ How long_______ Substance__________

Y N Drug abuse (substance____)

Y N Immunizations (Please list type and age received):______________________

____

Young ladies only:

Onset of Menstruation (age___________)

Is there any of the following:

Cramping Yes No

Vaginal Discharge Yes No

Fluid Retention Yes No

Please list any other significant data (i.e. hospitalizations, surgeries, accidents, traumas, current medications) ____

____

____

Authorization for physician to treat

I hereby authorize the chiropractic physicians of Masterson Chiropractic Clinic and whomever they may designate to administer care as they deem necessary to my child.

Parent or Guardian_____________________________________Date_____________