

# Wellness Concepts of Florida

## Pediatric History

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Age of Siblings \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Responsible Party's Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party's SS# \_\_\_\_\_ Work Phone \_\_\_\_\_

Chief Complaint \_\_\_\_\_

Previous Doctor of Chiropractic \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Present MD and address \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Birth History ( C-section, forceps, suction, other difficulties, normal, etc ) \_\_\_\_\_

Accidents \_\_\_\_\_

Illness/Hospitalization \_\_\_\_\_

Family History (Health problems with parents of siblings) \_\_\_\_\_

Sleep Patterns \_\_\_\_\_

Exercise Routine \_\_\_\_\_

Temperament and Social Interactions \_\_\_\_\_

Does anyone in the household smoke? \_\_\_\_\_

### Child's Daily Dietary Habits (Please Circle)

Fruits	Vegetables	Protein	Sugar	Milk
Grains	Wheat	Soda	Juice	Other _____

Frequency of eating \_\_\_\_\_

Types of snacks \_\_\_\_\_

Infant Milk:      Human              Formula              Cow: 2% / Whole              Goat

Is there anyone you would like us to keep informed regarding your child's treatment at this office? E.g. family physician, referring doctor, etc. ( ) yes      ( ) no      Please specify name and address, if known \_\_\_\_\_

I hereby authorize Wellness Concepts of Florida and whomever they may designate as their clinicians to administer care as they so deem necessary to my child/ward (listed above). I accept responsibility for payment for services rendered.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_ Witness \_\_\_\_\_