Pediatric History

Takahashi Chiropractic, Inc.

Brandon Takahashi, D.C.

Name_____ Social Sec. #_____
Address:_____ City:_____
State:_____ Zip Code:_____ Phone#:_____
Birth Date _____/_____/_____ Sex: F / M
How did you hear about us? _____
Name of parents/guardians :_____

Reason for your visit?_____
Is your son or daughter being treated by a doctor? Yes_____ No_____
Name of the doctor:_____
Medical Problems:_____

Please check all current conditions or conditions your child has had in the past 6 months:
( ) Ear infection ( ) Scoliosis ( ) Seizures ( ) Chronic Cough ( ) Headache
( ) Asthma/Allergies ( ) Digestive Problems ( ) ADHD ( ) Fever ( ) Growing pains
( ) Colic ( ) Bed Wetting ( ) Car Accident ( ) Temper Tantrums ( ) Other condition:_____
Medical History: _____

Name of chiropractor:_____
Date:_____/_____/_____ Reason: _____

Name of doctor:_____
Date of visit:_____/_____/_____ Are you happy with the care you receive there? Yes:___ No:__

How many doses of antibiotics has your child taken in the past?
In the last 6 months:_____ During his/her life:_____
How many doses of other medications has your child had?
In the last 6 months:_____ During his/her life:_____
Has your child received immunizations? Yes_____ No_____

Prenatal History:
Name of obstetrician or mid-wife:_____
Any complications during your pregnancy? No_____ Yes_____ If yes list them:_____
How many ultrasounds did you have done?:_____
Did you take any medications during your pregnancy or labor?: No_____ Yes:_____
If yes list them:_____
Did you smoke or drink during your pregnancy?: Yes_____ No_____
Where did you have your son/daughter?: _____hospital _____ mid wife _____at home