HEALING HANDS CHIROPRACTIC
PEDIATRIC PATIENT INTRODUCTION

Child's name: _____ Date: _____
Referred by: _____

Birth date: _____ Age: _____ Sex: _____ Number of siblings: _____
Current height: _____ Current weight: _____

Has the child been seen at this office before? □ Yes □ No
Date of last visit: _____ Purpose: _____
Previous Chiropractor: _____
Date of last visit: _____ Purpose: _____
Has your child ever been treated in an emergency situation? □ Yes □ No
Please explain: _____

Why are you seeking care for your child today?

_____

When did this problem begin: _____
Onset was: □ Sudden □ Gradual □ Associated with an event

How did it begin: _____

Duration of problem or episode: □ Minutes □ Hours □ Days □ Months □ Years
Pattern of problem: □ Constant (76-100% of day) □ Frequent (51-75% of day) □ Occasional (26-50% of day
□ Intermittent (0-25% of day)

Aggravation factors: _____
Relieving factors: _____

How does the problem affect your child's daily activities? _____

_____
Prior occurrences or episodes? _____
Other health concerns? _____

PEDIATRIC CASE HISTORY

HISTORY OF BIRTH
Third Trimester Presentation: □ Vertex □ Breech □Transverse □ Face/Brow
Duration of Gestations: _____ Weeks
Location of Birth: □ Home □ Birthing Center □ Hospital

Type of Birth: □ Normal Vaginal □ Vaginal w/Epidural □ Forceps □ Vacuum Section □ Cesarean Section
Hours of Labor: _____ Minutes of pushing: _____

Were medications given to the mother at birth? □ Yes □ No
If yes, what? _____

Were there any complications during delivery? □ Yes □ No
If yes, what? _____

Congenital Anomalies /Defects? □ Yes □ No
If yes, please explain:

_____

Growth and Development

Were there any delays of the following milestones: □ Respond to sound □ Follow an object
□ Hold up head □ Vocalize □ Sit alone □ Crawl □ Walk

Normal sleeping patterns? □ Yes □ No If no, please describe: _____

Describe any health problems on the mother's side of the family: _____
_____
Describe any health problems on the father's side of the family: _____
_____

Do the child's siblings have health problems? □ Yes □ No
If yes, please describe: _____

At what age, if ever, did the child suffer from the following childhood diseases?
Chickenpox: _____ Mumps: _____ Measles: _____ Rubella: _____
Rubeola: _____ Whooping cough: _____ Other: _____

Environmental Stressors

During pregnancy, did the mother:

1. Smoke: □ Yes □ No
2. Drink: □ Yes □ No
3. Take supplements: □ Yes □ No If yes, what? _____
4. Take drugs: □ Yes □ No If yes, what? _____
5. Become ill: □ Yes □ No
6. Receive a vaccination □ Yes □ No If yes, what? _____
7. Receive an ultrasound □ Yes □ No If yes, how many? _____
8. Receive an invasive procedure (i.e. Amniocentesis, cvs)? □ Yes □ No

Was your child breastfeed? □ Yes □ No If yes, for how long? _____
At which age was formula introduced? _____ Which brand? _____
At which age was cow's milk introduced? _____ Soy milk? _____ Solid foods? _____

Did your child receive vaccinations? □ Yes □ No
If yes, please list: _____
Did your child react to the vaccinations? □ Yes □ No

Has your child been prescribed antibiotics? □ Yes □ No
If yes, how many courses and why? _____

Is the child around pets at home? □ Yes □ No
Are there smokers in the home? □ Yes □ No

Mental Stressors

Any difficulties with lactation? □ Yes □ No Difficulties bonding? □ Yes □ No
Have you noticed any changes in behavior? □ Yes □ No
Does your child have difficulty sleeping? □ Yes □ No

Does your child go to daycare? □ Yes □ No If yes, from what age? _____
Average hours of TV/computer per week? _____

Physical Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □Stuck in birth canal
□ Fast or long birth □ Respiratory depression □ Cord around neck □ Other

Any falls/accidents during pregnancy? □ Yes □ No

Has this child ever suffered from:

- □ Headaches
- □ Dizziness
- □ Fainting
- □ Seizures/ Convulsions
- □ Heart trouble
- □ Chronic earaches
- □ Sinus trouble
- □ Asthma
- □ Colds/flu
- □ Colic
- □ Orthopedic problems
- □ Neck problems
- □ Eczema
- □ Loss of consciousness
- □ Urinary tract infections
- □ Hepatitis or jaundice
- □ Arm problems
- □ Leg problems
- □ Joint problems
- □ Backache
- □ Poor posture
- □ Scoliosis
- □ Walking trouble
- □ Broken bones
- □ Digestive disorders
- □ Poor appetite
- □ Stomach aches
- □ Reflux
- □ Constipation
- □ Diarrhea
- □ Diabetes
- □ Hypertension
- □ Anemia
- □ Bed wetting
- □ Behavioral problems
- □ ADD/ADHD
- □ Ruptures/hernia
- □ Muscle pain
- □ Growing pains
- □ Allergies
- □ Vision problems
- □ Hearing problems
- □ Nose bleeds
- □ Other_____

Has the child ever suffered from any major falls/accidents? □ Yes □ No
If yes, please explain: _____

Has the child ever sustained an injury playing organized sports? □ Yes □ No
If yes, please explain: _____

Has the child ever sustained an injury in an auto accident? □ Yes □ No
If yes, please explain: _____

Weight of school backpack: _____
Surgery: _____
Current and past medications: _____

Signature of Parent / Guardian: _____

Date: _____