PEDIATRIC PATIENT HISTORY (Ages 0-5)

CALCARA FAMILY CHIROPRACTIC PS 1946 4TH AVE E, OLYMPIA, WA 98506 (360) 352-3333

CHILD'S NAME: _____ AGE: _____ BIRTHDATE: _____ TODAY'S DATE: _____

NAMES OF PARENTS/GUARDIANS:_____

CHILD'S SEX: ☐ M ☐ F NUMBER OF SIBLINGS: _____ THEIR AGES: _____

REASON FOR THIS VISIT: ☐ Wellness check-up ☐ There is a problem: _____

WHAT ARE YOUR CONCERNS ABOUT YOUR CHILD'S HEALTH? _____

_____

_____

_____

MOM'S PREGNANCY: During the pregnancy, did the mother:

☐ Experience any illness or injuries? Explain: _____

☐ Experience morning sickness ☐ Yes ☐ No How long? _____

☐ Take medications? List: _____

☐ Smoke or consume alcohol or drugs? List: _____

☐ Undergo excessive stress? Reason: _____

☐ Have any complications? List: _____

BIRTHING PROCESS ☐ Born at full term ☐ Premature birth (____weeks early) ☐ Overdue birth (_____weeks late)

Birthplace: ☐ Birthing center ☐ Home ☐ Hospital ☐ Other _____ Birth Assistant: ☐ OB/GYN ☐ Midwife ☐ Doula

Type of birth: ☐ Vaginal ☐ Planned C-Section ☐ Emergency C-Section Baby's Position: ☐ Head down ☐ Breech_____

Was labor chemically induced? ☐ Yes ☐ No How long did labor and delivery last? _____

Unnatural Procedures: ☐ Forceps ☐ Vacuum Extraction ☐ Epidural ☐ Episiotomy ☐Other_____

Any labor or birth difficulties or complications? _____

_____

Any congenital defects or problems? _____

Birth weight: _____ Length:_____ Has baby had proper weight gains? ☐ Yes ☐ No

INFANCY Hours of sleep/night:_____ Quality: ☐ Good ☐ Fair ☐ Poor Good napper? ☐ Yes ☐ No

Infant Nutrition: ☐Breastfed- How long? _____ ☐Bottle-Starting when? _____ Type of formula?_____

DEVELOPMENTAL HISTORY: At what age did you child: Respond to sound _____ Follow objects with eyes _____
Hold up head _____ Crawl _____ Sit alone _____ Stand _____ Walk alone _____

HEALTH CARE/SICK CARE

HAS YOUR CHILD EVEN BEEN CHECKED OR ADJUSTED BY A CHIROPRACTOR? ☐ NO ☐ YES WHO? _____

City? _____ At what age? _____ Results: _____

PEDIATRICIAN/HEALTH PROVIDER: _____ City: _____ Phone: _____

Date of last visit: _____ Purpose: _____

VACCINATIONS Is your child vaccinated? ☐ Yes ☐ No Any reactions to the vaccines: _____

ARE THERE ANY VACCINES YOU HAVE CHOSEN TO AVOID? ☐ Yes ☐ No Reason: _____

Has your child had any antibiotics or other drugs? List the drug and when given: _____

_____

HAS YOUR CHILD EVER: ☐ Been treated on an emergency basis? ☐ Had surgery? Explain: _____

_____

CHILDHOOD DISEASES: ☐ CHICKEN POX ☐ MUMPS ☐ MEASLES ☐ OTHER: _____

HEALTH HISTORY HAS THIS CHILD EVER SUFFERED FROM THE FOLLOWING? (Check those that apply; "circle" if a current problem)

__ COLIC	__ CHRONIC EAR-ACHES	__ SLEEP PROBLEMS	__ NURSING/LATCHING PROBLEMS
__ ADHD	__ AUTISM/SPECTRUM DISORDER	__ SEIZURES	__ FEBRILE SEIZURES
__ DIABETES	__ HYEPERACTIVITY	__ "GROWING PAINS"	__ HEADACHES
__ BED WETTING	__ BEHAVIORAL PROBLEMS	__ STIFF NECK	__ RECURRING COLDS/FLUS
__ ASTHMA	__ ALLERGIES	__ STOMACH ACHES	__ BLOOD DISORDERS
__ DIGESTIVE DISORDERS	__ SINUS TROUBLE	__ CONSTIPATION	__ DIARRHEA
__ ANEMIA	__ RHEUMATIC FEVER	__ JOINT PROBLEMS	__ HEART TROUBLE
__ POOR APPETITIE	__ CONVULSIONS	__ PARALYSIS	__ MUSCLE JERKING
__ FAINTING	__ WALKING PROBLEMS	__ BROKEN BONES	__ RUPTURES/HERNIAS
__ ARM PROBLEMS	__ LEG PROBLEMS	__ BACKACHES	__ SCOLIOSIS

__ FOOD ALLERGIES _____

__ MAJOR LIFE OR FAMILY STRESS EVENT: _____

__ ANY OTHER HEALTH ISSUE OR DISEASE _____

PLEASE DESCRIBE ANY FALLS, INJURIES OR OTHER ACCIDENTS: _____

_____

FAMILY HISTORY: List any history of serious or congenital conditions in the family: _____

_____

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO EXAMINE AND ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY TO MY CHILD. I REALIZE THAT I AM REPSOSIBLE FOR ALL FEES CHARGED BY THE CLINIC AND THAT I WILL PAY OR ALL SERVICES AS THEY ARE PERFORMED.

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____