PEDIATRIC PATIENT HISTORY (Ages 6-12)

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? _____

_____

_____

WHEN DID THIS BEGIN? _____ HOW DID THIS BEGIN? _____

HOW OFTEN IS THIS PRESENT? ☐ Constant ☐ Off and on, daily ☐ Occasional ☐ With certain activities _____

HOW SEVERE IS THIS PROBLEM NORMALLY? (Severity rated from 0-10) _____ AT ITS WORST? (0-10) _____

WHAT MAKES IT WORSE? _____

WHAT MAKES IF LESSEN? _____

HOW DOES THIS AFFECT HER/HIS ABILITY TO DO THINGS (AT HOME, SCHOOL, SLEEP, RECREATION, ETC.)? _____

_____

WHAT HAS BEEN TRIED FOR THIS CONDITION, AND WHAT WERE THE RESULTS? _____

_____

WHAT DO YOU THINK IS THE CAUSE OF THE PROBLEM? _____

DEVELOPMENTAL HISTORY: WERE THERE ANY COMPLICATIONS OR MAJOR STRESSES DURING MOTHER'S PREGNANCY? Explain:

_____

BIRTH HISTORY: ☐ Born at Full Term ☐ Premature birth (_____ weeks early) ☐ Overdue birth (_____ weeks late)

Type of birth: ☐ Vaginal ☐ Planned C-section ☐ Emergency C-section ☐ Forceps ☐ Vacuum Extraction

Were there any complications during child's birth? _____

CHILDHOOD STRESSES (indicate age): Falls ☐ Learning to walk ____ ☐ Riding bike ____ ☐ Other falls _____

☐ Death of loved one _____ ☐ Parental Divorce _____ ☐ Major Illness in family _____ ☐ Auto accidents _____

☐ Fights/Abuse/Bullying _____ ☐ Sports injuries _____ ☐ Change of schools or residence _____

Other _____

(Continued on back side)

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: _____

LIST ANY MEDICATION OR NATURAL REMEDIES YOUR CHILD CURRENTLY TAKES: _____

_____

HAS YOUR CHILD EVER: ☐ BEEN TREATED ON AN EMERGENCY BASIS? ☐ HAD SURGERY? EXPLAIN: _____

_____

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
__ CHICKEN POX	__ MUMPS	__ MEASLES	__ WHOOPING COUGH
__ 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 _____

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: _____