PEDIATRIC HEALTH HISTORY

Our purpose is to educate and adjust as many families as possible towards optimal health through natural Chiropractic care and/or Acupuncture, in order to create a healthier community so that they may positively impact the world.

Child's Name _____ Age _____ Birth date (DD/MM/YY) _____

Address _____ City _____ Postal Code _____

Parent's Cell _____ Home phone _____ Names of Parents / Guardians _____

Twitter @_____ Email _____

Child's Cell _____ Names (and Ages) of other children _____

Whom may we thank for referring you/your child? _____

Previous Chiropractic and/or Acupuncture care? _____ When? (Include last visit date) _____
Where? (Include Dr's Name & Phone #) _____
Why? _____
Were X-rays taken? (Include date) _____

Main reason for consulting this office: _____
Other health concerns: _____
How long has your child had this condition? _____ Has your child had this or similar conditions in the past? _____
What activities aggravate this condition? _____
Is this condition getting progressively worse? (Circle) Yes No Constant Comes and goes
Is this condition interfering with: (Circle) .... School Sleep Daily routine Other _____
Other Doctors/Therapists who have treated this condition _____
Circle any of the following conditions your child has suffered:

Asthma / Allergies	ADHD / ADD	Bed wetting	Colic	Chronic colds / Flu
Digestive problems	Ear infections / Tubes in ears		Fevers (Recurring)	"Growing"/ Back pains
Headaches	Scoliosis	Seizures	Other _____	

Pediatrician's Name & Phone # (Include last visit date & reason) _____
List any diagnosed medical conditions: (eg. Juvenile Diabetes, etc) _____
Drugs your child now takes: (Circle) Antibiotics Ritalin Inhaler Other _____
Drugs taken in the past: _____
Vaccinations: _____ Adverse Reactions? _____
Allergies or adverse reactions to any medication? (eg. Upset Stomach, Hives, etc) _____
Allergies or adverse reactions to any foods? (eg. Nuts, Milk, etc) _____

Has your child experienced much stress lately? _____ Does your child get enough sleep regularly? _____
How much water does your child drink daily? _____ Does your child eat well balanced meals regularly? _____
What hobbies/activities does your child do? _____
Is your child generally happy? _____

What is your health goal for your child? (Circle one)

1. RELIEF CARE: Only relieves the pain and symptoms.
2. CORRECTIVE CARE: Addresses the cause of the problem as well as reduces the pain and symptoms.
3. WELLNESS CARE: Corrects the cause of the problem as well as allows the body to function to its maximum health potential.

Do you (or your spouse) have Extended Health Care Insurance? _____ Yearly limit amount: _____

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PRENATAL HISTORY:

Name of Obstetrician / Midwife & Phone #: _____

Complications during pregnancy: _____

# of ultrasounds during pregnancy: _____ Medication during pregnancy: _____

During pregnancy, the mother: (Circle).... Smoked Drank alcohol Drank caffeine

Location of birth: _____

Birth details: (Circle) Breech Cesarean (ER or planned?) Forceps Vacuum extraction Episiotomy Natural

Medications during birthing process (eg. Epidural, etc) _____

Complications during birthing process: _____

Genetic disorders or Conditions (eg. Inguinal Hernia, etc) _____

Birth weight: _____ Apgar scores: (Circle) Normal Abnormal

FEEDING HISTORY:

Breast fed (How long) _____ Formula fed (How long) _____

Feeding problems or concerns? _____

DEVELOPMENTAL HISTORY:

During the following stages of development your child's nervous system and spine are vulnerable to tremendous stress. During this time your child should be routinely checked by a Chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference preventing optimal health and function).

At what age (approximately) was your child able to:

_____ Hold head up / sit up _____ Crawl _____ Walk

Approximately 50% of children fall head first from a high place during their first year of life (eg. a Bed, Down Stairs)

Did this happen to your child? (Describe) _____

_____

Does your child participate in any high impact or contact sports? (eg. Soccer, Football, Gymnastics, etc) _____

_____

Has your child ever been in a car accident? (Describe) _____

Has your child ever been seen on an emergency basis? (Describe) _____

Any other traumas? _____

List any surgical procedures and dates: _____

Age of onset of menstrual cycle: _____ Any complications? _____

Any puberty problems or concerns? _____

CHILDHOOD DISEASES: (Circle)

Chicken pox Mumps Measles (Rubeola) German Measles (Rubella) Other: _____

AUTHORIZATION FOR CARE OF MINOR:

I hereby authorize this office and its Doctors to administer Chiropractic care and/or Acupuncture to my child as they deem necessary.
I understand and agree that I will be solely responsible for any and all fees:

_____ _____

PARENT SIGNATURE (or Guardian) DATE

_____

WITNESS

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