PEDIATRIC (AGES 5-11) HEALTH RECORD

NAME: ______________________ PARENT'S HOME PHONE: ______________________
STREET ADDRESS / P.O. BOX ______________________ PARENT'S MOBILE PHONE: ______________________
CITY / STATE / ZIP: ______________________ PARENT'S WORK PHONE: ______________________
SOCIAL SECURITY NUMBER: ______________________ CHILD'S BIRTHDATE: ______________________
MOM'S NAME: ______________________ INSURED'S EMPLOYER: ______________________
DAD'S NAME: ______________________ FAMILY EMAIL: ______________________
NAMES / AGES OF OTHER CHILDREN AT HOME: ______________________

PATIENT DEMOGRAPHICS

(*REQUIRED PER FEDERAL GUIDELINES)

***GENDER:** ☐MALE ☐FEMALE ***ETHNICITY:** ☐HISPANIC ☐NOT HISPANIC

***RACE (SELECT ONE):** ☐ALASKA NATIVE ☐AMERICAN INDIAN ☐ASIAN ☐BLACK/AFRICAN AMERICAN ☐NATIVE HAWAIIAN ☐OTHER PACIFIC ISLANDER ☐WHITE/CAUCASIAN ☐OTHER: ______________________

***PREFERRED LANGUAGE:** ☐ENGLISH ☐HMONG ☐LAO ☐SPANISH ☐VIETNAMESE ☐OTHER: ______________________

***DRUG ALLERGIES:** ☐NONE **-OR-** ☐ LIST: ______________________

***CURRENT PRESCRIPTION MEDICATIONS** *NAME OF PRESCRIPTION (BRAND OR GENERIC)*	**DOSE** *(MG, ML, ETC.*	**FORM** *(TAB, CAPS, INJ., ETC.)*	**FREQUENCY** *(# PER DAY/WEEK/MO.)*
______________	________	________	____ *x PER* ____
______________	________	________	____ *x PER* ____
______________	________	________	____ *x PER* ____
______________	________	________	____ *x PER* ____
______________	________	________	____ *x PER* ____

*** HOW DO YOU PREFER TO RECEIVE FOLLOW-UP REMINDERS FOR PREVENTATIVE CARE? (SELECT ONE)**

☐LETTER BY MAIL ☐PHONE ☐E-MAIL: ______________________

☐ **I ELECT TO DECLINE AUTOMATED CLINICAL SUMMARIES AFTER EVERY VISIT** *(THE SUMMARIES ARE OFTEN BLANK AS A RESULT OF THE NATURE & FREQUENCY OF CHIROPRACTIC CARE.)* **I UNDERSTAND THAT I CAN STILL VIEW MY RECORDS ON THE PATIENT PORTAL OR REQUEST INDIVIDUAL VISIT SUMMARIES AT ANY TIME.**

PLEASE PROVIDE:

Height: ________ inches; **Weight:** ________ lbs.;

DOCTOR WILL GATHER:

Blood Pressure: ________ / ________ (Sit / Stand)

Temp:________ **Resp:**________ **Pulse:**________

History of Present Illness / Injury

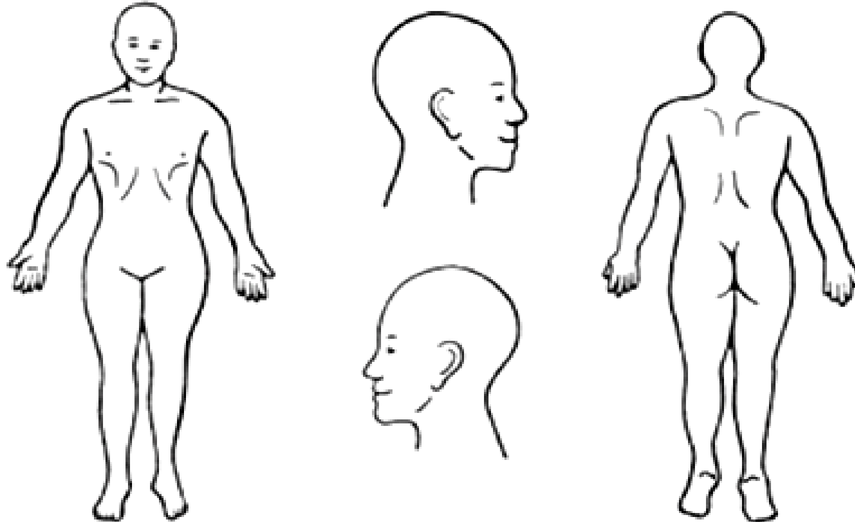
Fill out this section by marking the area with the described sensation using symbols from the left.

X X X Burning Pain
((((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain

Please Complete:
_____ Constant
_____ Come & Go

_____ Getting Better
_____ Getting Worse
_____ Staying Same

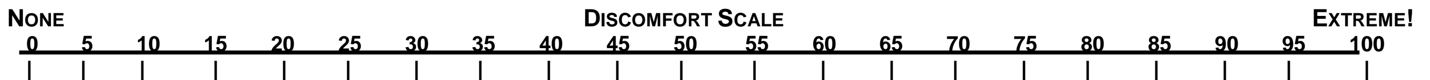
Better: Worse:
_____ AM _____
_____ Mid-Day _____
_____ PM _____



If Applicable, Rate Your Discomfort/Symptom(s):

Enter the number below that corresponds with your degree of discomfort. **"0"** is no pain/symptom(s), **"100"** is intolerable Pain/Symptoms.

None **Discomfort Scale** **Extreme!**



Why Have You Decided to Have Your Son/Daughter Evaluated by a Chiropractor?

☐ He/She is Continuing Ongoing Care from Another Chiropractor.
☐ I Recently Had My Spine Checked By a Chiropractor and Understand the Value in Getting My Child Checked.
☐ I Have Concerns About His/Her Health and I've Learned that Chiropractic May Be Able to Help.
☐ He/She is Extremely Active and I Want to be Sure Their Body Handles the Physical & Mental Strain
☐ I Want to Improve My Child's Immune Function & Overall Well-Being.

Do You Have a Specific Concern for Your Child That Brings You In?

☐ No, I'm interested in having my child's spine and nervous system assessed to achieve optimal health and functioning.
☐ Yes. please answer the following questions:

Describe Specific Symptom(s) or Concern(s): ____________________
How Did It Begin? ____________________ When Did It Start? ____________________
What Have You Tried So Far to Remedy the Problem(s): ____________________

Yes No

☐ ☐ Any Recent Loss of Appetite or Change in Eating Habits? How? ____________________
☐ ☐ Any Recent Change in Bathroom Habits? How? ____________________
☐ ☐ Any Change in Sleeping Habits? How Many Times Does It Wake Them Up? ____________________
☐ ☐ Do They Sleep with a Pillow? How Many? __________ Where are They Placed? ____________________
♦What Positions Do They Sleep In? __________ How Old is Their Mattress? ____________________

What Makes the Condition Better?

Head / Neck ____________________
Mid Back ____________________
Low Back ____________________
Shoulder, Arm, Hand ____________________
Hip, Leg, Foot ____________________
Other ____________________

What Makes the Condition Worse?

Head / Neck ____________________
Mid Back ____________________
Low Back ____________________
Shoulder, Arm, Hand ____________________
Hip, Leg, Foot ____________________
Other ____________________

Past Medical History

How Many Times Has Your Child Had the Condition That They Are Seeing Us for Today? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Has Your Child Suffered From Any of the Following Conditions Now or In the Past?

☐ ADD/ADHD ☐ Asthma ☐ Autism ☐ Back Pain ☐ Bed-Wetting ☐ Rashes ☐ Ear Infections
☐ Frequent Colds ☐ Scoliosis ☐ Growing Pains ☐ Headaches ☐ Tonsil Problems ☐ Head Tilt ☐ Stomach Pains
☐ Frequent Falls ☐ Anxiety ☐ Refusal to Eat ☐ Allergies ☐ Sports Injuries ☐ Learning Difficulties

YES NO

☐ ☐ **Does Your Child Suffer From Any Other Health Condition(s)?** (Diabetes, Cancer, Others) If YES, Please Explain:
____
____

☐ ☐ **Has Your Child Ever Seen a Chiropractor Before?**

- ♦ When Was the Last Time They Were Seen? ____________ Which Dr.? ____________
- ♦ For What Problem(s)? ____________ Were They Helped? ____________
- ♦ How Often Were They Being Seen? ____________ Why Did You Leave? ____________
- ♦ List Any Other Chiropractors Your Child has Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

☐ ☐ **Has Your Child Ever Seen a Medical Doctor for This Condition?** (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

☐ ☐ **Describe Any Major Illnesses, Injuries, Falls, Hospitalizations, Auto Accidents, and/or Surgeries:**

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

☐ ☐ Have They ever Had X-Rays? When? ____________ What Body Parts? ____________

☐ ☐ Does Your Child Try to "Crack" Their Own Neck and/or Back? Explain: ____________

Birth & Rearing History

Were There Any Complications During Pregnancy? ☐ No ☐ Yes, Explain: ____________

Was Your Child's Birth: ☐ On Time ☐ Early ☐ Late Explain: ____________

Was the Child's Delivery: ☐ Vaginal ☐ Cesarean (C-Section) How Long was Labor? ____________

Was the Child Born: ☐ At Home ☐ In Hospital ☐ Who Was Your Midwife / Doctor? ____________

What Was The Child's Birth Measurements? ☐ Weight: ____________ ☐ Length: ____________

YES NO

☐ ☐ Were Extraction Aids (Forceps/Suction) Used? ____________

☐ ☐ Was There More Than One Fetus? If Yes, Explain: ____________

☐ ☐ Did the Mother Use any Alcohol or Smoke During Pregnancy? If So, How Much? ____________

☐ ☐ Did the Mother Use any Pre-Natal Vitamins? If No, Why Not? ____________

☐ ☐ Is/Was Your Child Vaccinated? If Yes, Describe Any Adverse Reactions: ____________

☐ ☐ Is/Was Your Child Breastfed? If Yes, Describe Any Difficulties: ____________

☐ ☐ Did/Does Your Child Use Formula? If Yes, Describe Any Difficulties/Allergies: ____________

Parental Instincts

Do You Feel Your Child is Developmentally Appropriate for Their Age,

Intellectually: ☐ **Yes** ☐ **No**, Explain: ____________________

Emotionally: ☐ **Yes** ☐ **No**, Explain: ____________________

Physically: ☐ **Yes** ☐ **No**, Explain: ____________________

What Is Your Primary Goal(s) for Your Child at Our Clinic? ____________________

Family Health History

Health Status of Family Members. (List Any Current or Past Health Conditions. Or if Deceased, at What Age and From What?)

Mother: ____________________

Father: ____________________

Sister(s): ____________________ How Many? __________

Brother(s): ____________________ How Many? __________

System Review Questions

Have You Had Any Problems with the Following Areas Now or in the Past? (Please Mark **Y** for Yes or **N** for No in Each of the Following:)

1. ____ **Eyes** (glasses, Lazy Eye, pink eye, glaucoma, Etc.)
2. ____ **Ears, Mouth, Nose, Throat** (ear infections, sinus, Etc.)
3. ____ **Cardiovascular** (heart, murmur, irregular beat, Etc.)
4. ____ **Respiratory** (lungs, breathing, asthma, RSV, Etc.)
5. ____ **Neurological** (nerve issues, weakness, numbness, Etc.)
6. ____ **Endocrine** (Menstrual, hormonal imbalances, liver, Etc.)
7. ____ **Gastro-Intestinal** (acid reflux, constipation, diarrhea, etc.)
8. ____ **Genito-Urinary** (bed wetting, kidneys, bladder, hernias, Etc.)
9. ____ **Musculoskeletal** (breaks, arthritis, scoliosis, Etc.)
10. ____ **Skin** (rashes, dryness, psoriasis, eczema, hair, Chicken Pox, Etc.)
11. ____ **Dietary Sensitivity** (Dairy, Gluten, Corn, Flour, Sugar, Etc.)
12. ____ **Others**: ____________________

Please Describe in More Detail: ____________________

____

Treatment Options

☐ I Want the Doctor to Explain More

☐ I Want the Doctor to Choose for Us

With What you Know Now, How Do You Want Us to Approach Your Child's Care?

☐ Phase 1: **Temporary Pain Relief:** (Help Calm the Symptom(s), But Do Not Fix the Problem Long Term).

- pro: Quick, Inexpensive, Mask the Problem — con: Symptoms Likely to Return or Relapse in the Future

☐ Phase 2: **Total Correction:** (Calm the Symptom(s) & Resolve the Cause of the Problem for Future Stability).

- pro: Longer Lasting Results, Fixing the Problem — con: Continued Care After Initial Symptoms Have Calmed

E 3: **Maximum Correction Followed by a Regular Wellness Schedule**: (*To Be Determined by Your Doctor*)

- pro: Maintain Gains & Prevent Future Problems — con: Staying Motivated, Increased Time & Effort Commitment

Notes:

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: ____________________ Date: __________

Guardian Signature: ____________________ Date: __________

D.C. / C.T. Signature: ____________________ Date: __________