Van Roo
FAMILY CHIROPRACTIC

PEDIATRIC (Ages 0-11) HEALTH RECORD

Patient Demographics (*Required per Federal Guidelines)

NAME: _____ PARENT'S HOME PHONE: _____

STREET ADDRESS / P.O. BOX _____ PARENT'S MOBILE PHONE: _____

CITY / STATE / ZIP: _____ * GENDER: ☐ MALE ☐ FEMALE _____

SOCIAL SECURITY NUMBER: _____ CHILD'S BIRTHDATE: _____

MOM'S NAME: _____ DOB: _____ INSURED'S EMPLOYER: _____

DAD'S NAME: _____ DOB: _____ FAMILY EMAIL: _____

NAMES / AGES OF OTHER CHILDREN AT HOME: _____

WHO IS THEIR FAMILY MEDICAL DOCTOR? _____ FACILITY / CITY: _____

HOW WERE YOU REFERRED? ☐MY M.D. ☐INS. PLAN ☐ANOTHER PERSON: _____ OTHER: _____

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

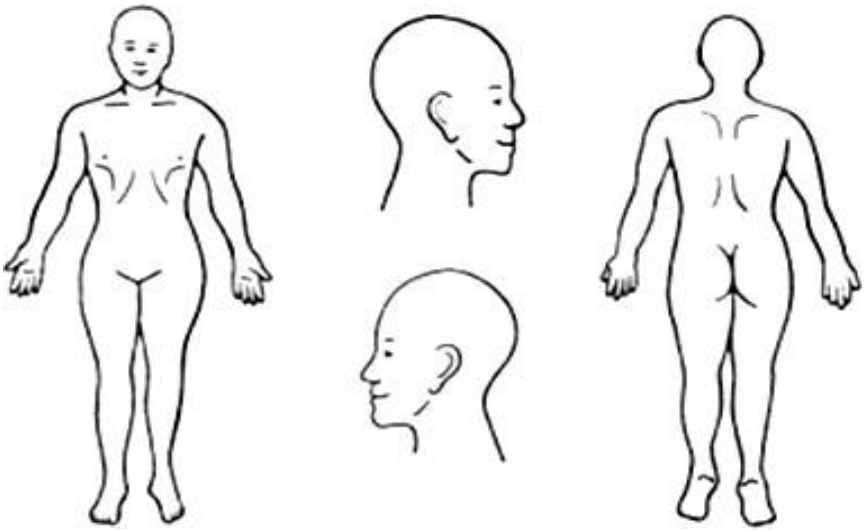
HISTORY OF PRESENT ILLNESS / INJURY

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!**

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

DO YOU HAVE A SPECIFIC CONCERN FOR YOUR CHILD THAT BRINGS YOU IN?

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 _____

***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* _____

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? _____

OFFICE USE ONLY:

Blood Pressure: _____/ _____ (Sit / Stand)

Height: _____inches; **Weight:** _____lbs.; **Temp:** _____ **Resp:**_____ **Pulse:**_____

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 <u>Other</u> 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

☐ ☐ 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: _____

Is there anything else you would like to discuss with the doctor?

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FAMILY CHIROPRACTIC

Dr.'s 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: _____