DENN CHIROPRACTIC
Healing the Body From Within

Pediatric Health History Form

(0-24 Months)

Patient Information

Date: _____ / _____ / _____

Child's Name:_____ Date of Birth: ____ / _____ / _____

Parent/Guardian Name:_____ Relationship to child:_____

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Pregnancy and Birth History

Type of Birth: ___Normal Vaginal ___Cesarean ____Forceps ____Breech

Place of Birth: ___Hospital ___Home ___Birthing Center ____Other _____

Time frame of Birth: ___Premature ___Full Term ___Over due

Problems during Pregnancy? ____No ____Yes If yes, please explain_____

Problems during Delivery? ____No ____Yes If yes, please explain_____

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Child's Health History

Infant feeding: ____Breast ___Bottle ___Formula Quality of Sleep: ___Good ___Fair ___Poor

Immunization History: ___Up to Date ___Exempt Hours of sleep/night: _____

Please check each of the following that your child has now or in the past.

___Colic ___Ear infections ___Sleeping issues ___Sinus issues ___Fevers ___Constipation ___Diarrhea

___Falls ___Frequent colds ___Breathing issues ___ADHD ___Torticolis ___Latching issues ___Fevers

___Vomiting ___Teething issues ___Other_____

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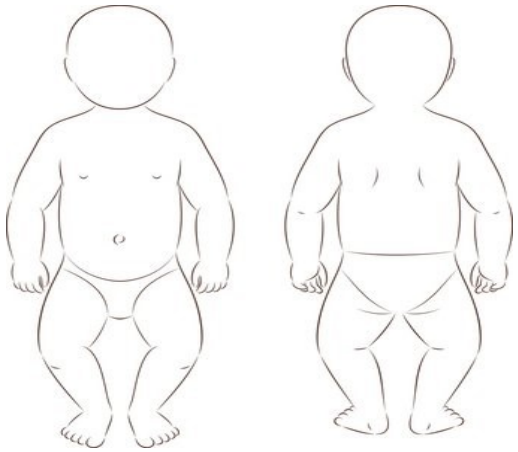
Please indicate the areas of concern on the diagram



Reason for seeking Chiropractic care today_____

Have you consulted with any other treatment/Provider for this ?

___No ___Yes If Yes, Who/What_____

Are you concerned with your child having possible pain? ___No ___Yes

If Yes, please explain:_____

Are you concerned about any signs/symptoms your child is having?

___No ___Yes If Yes, please explain:_____

Do you notice any irregular positions /postures? ___No ___Yes

If Yes, please explain:_____