Pediatric Health history form (2-5 years old)

Patient Information:

Date:___________________________

Childs Name:_____________________________________ Age:_____ Date of birth: ____/_____/_____

Parent/Guardian Name:_____________________________________ Relation to child:_________________

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Medical History:

Pediatrician/Family MD:____

Has your child been vaccinated? Yes______ No______ Are they up to date? Yes_____ No______

Does your child take any medications/vitamins? Yes_____ No_____

If yes, please list____

Has your child ever had chiropractic care? Yes_____ No____ If yes, when _________________________________

Reason for previous chiropractic care____

Has your child ever had any surgeries ? Yes_____ No_____ If yes, when/what_____________________________

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Child's Health History:

Please indicate each of the following that your child has now or in the past had:

___Allergies ___Asthma ___Neck pain ___ Mid-Back pain ___ADHD ___Sinus problems

___Headaches ___Low back pain ___Arm/Leg pain ___Frequents colds ___Dizziness ___Sleeping issues

___Ear Infections ___Falls/Injury ___Sports Injuries ___Car Accident ___Diarrhea ___Constipation

___Poor eating ___Stomach issues ___Fractures ___Fevers

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Daily Habits and Activities:

Does your child participate in any of the following (please circle)

Soccer Gymnastics Karate Hockey Basketball Dance Class Wrestling Baseball

Running Video Games Trampoline Tennis Fishing Camping Softball

*Other sport/activities:*____

Reason for this visit?___________________________________ **When did it begin?**______________________________

Please describe the pain:

___dull ___sharp ___achy ___stiff

___numb ___burning ___tingling ___tight

___stabbing ___shooting ___radiating

How often are the symptoms:

___constantly (76-100%) ___frequently(51-75%)

___occasionally (25-50%) ___intermittent (25% or less)

___coming/going (with certain actions/ movements)

Are the symptoms changing?

____Better ____No Change _____Getting worse

For how long? ________________________________

Has the child had these symptoms before? Yes / No

If yes, when___________________________________

Please grade your symptoms:

(0=no pain) (10=severe pain)

0 1 2 3 4 5 6 7 8 9 10

Is there anything that aggravates the condition ? (Please Circle)

Bending / Lifting / Twisting / Pushing / Pulling / Sitting

Standing / Running / Sleeping / Computer / Video games

*Other*____

Is there anything that relieves the condition? (Please Circle)

Icing / Heating pad / Resting / Lying down / Medications

Sitting / Standing / Exercise / Hot Bath / Stretching

Other____

Please circle areas of complaint(s)

Child's name:____ Relation to child:___________________________

Parent/Guardian's name:____ Date:_____________________________________

Parent/Guardian's signature: _______________________________________