CONFIDENTIAL PEDIATRIC HEALTH HISTORY

Welcome to our office. Please fill out the following form to the best of your ability to help Dr. Laura Dobrinsky provide you and your family with the best care possible. If you have any questions, or need help filling out the form please let us know.

PERSONAL INFORMATION

Child's Name: ____________________________ Gender: M F Date of Birth: ____________ Age: ____

Parents Name(s): ____ Number of siblings: ________

Address: ____

City *Province* *Postal Code*

Home Phone: _________________ Work: _____________________ Cell: ______________________

E-Mail: _______________________ *Is it okay to use your email to send reminders/office information?*
□ *Yes* □ *No*

Have you or your child ever received chiropractic care before? □ Yes □ No

Were you pleased with the care you received? □ Yes □ No

How did you hear about our office? ____

What is the **goal** of your visit? □ Health maintenance/optimization □ Health problem □ Both

Is your child receiving care from other health care professionals? □ Yes □ No

If so, please name them and their specialty: ____

Who is your family's primary care physician? ____

Address: ___________________________________ Phone: ______________________________________

Please list any **drugs** or **medications** your child is taking:

____

Please list any **vitamins/supplements/homeopathics**/other your child is taking?

____

Please list any **allergies** or **sensitivities** your child has? ____

CURRENT HEALTH INFORMATION

What health condition brings your child to our office?____

When did the signs or symptoms first appear? ____

How did the problem start? □ Suddenly □ Gradually □ Post-injury

Is this condition □ Getting worse □ Improving □ Intermittent □ Constant □ Not sure

What makes the problem better? ____

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What makes the problem worse? ____

Has your child ever had a similar condition? □ Yes □ No
Please explain; ____

Has your child ever been treated for this problem before? □ Yes □ No
Please explain; ____

Does your child eat well? □ Yes □ No Have regular bowel/bladder movements? □ Yes □ No

How much does your child currently weigh? ______ pounds How tall is your child? _______

HEALTH HISTORY

Child's birth was □ at home □ at a birthing center □ at the hospital

Did you go with a □ Midwife □ Obstetrician □ Family Physician

What was the name of your health care provider? ____

Child's birth was □ Natural vaginal without intervention/pain medication
□ Vaginal with interventions
□ Induction □ Pain medication □ Epidural □ Episiotomy
□ Vacuum extraction □ Forceps □ Manual extraction
□ Other: ____
□ C-section
□ Scheduled □ Emergency

Please list reasons for any interventions/complications:

____

Child's birth weight: _____ pounds Child's birth length: ______ inches

APGAR score at birth: _____/10 APGAR score after 5 minutes: ______/10

Has your child been in a motor vehicle accident? □ Yes □ No
If yes, please explain (and provide year); ____

Does your child play any sports? □ Yes □ No which ones? ____________________________________

GROWTH & DEVELOPMENT

Was your child alert and responsive within 12 hours after delivery? □ Yes □ No
If no, please explain: ____

At what age did your child;

Respond to sound ____ Follow an object____ Hold head up ____ Vocalize ____
Sit alone ____ Teeth ____ Crawl ____ Walk ____

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Please list any surgeries/hospitalizations including the year:

____

Please list any major injuries, accidents, falls or fractures including the year:

____

Is/was your child breastfed? □ Yes □ No If yes, for how long? ___________

Is/was your child formula fed? □ Yes □ No What type? __________________ What age? ________

At what age was your child introduced to cow's milk? ____ Solid foods at age? _____

Please list any food or juice intolerances? ____

Did mother smoke during the pregnancy? □ Yes □ No Drink alcohol? □ Yes □ No

On a scale of 1 to 5, how **stressful** was the pregnancy for the mother? ____/5

Did the mother have any illnesses or immune issues during the pregnancy? □ Yes □ No

If yes, please explain (include use of antibiotics, medications or interventions):

____

List any **drugs/medications** (including over the counter and vaccines) taken <u>during pregnancy</u>?

____

List any **supplements** taken <u>during pregnancy</u> (including brand)?

____

Was your child exposed to ultrasound during pregnancy? □ Yes □ No How many? ____

What were the medical reasons for the ultrasounds (if given)?

____

Do you have any pets at home? □ Yes □ No

Do you have anyone that smokes at home? □ Yes □ No

Has your child received any vaccinations? □ Yes □ No

If so, which ones and please list any reactions;

____

____

Has your child received any **antibiotics**? □ Yes □ No How many times? __________

What was/were the reason(s) for the antibiotics? ____

Does your child get a "cold" often (or flu-like symptoms)? □ Yes □ No How many times a year?_____

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Any difficulty with **breastfeeding**? □ Yes □ No

If yes, please explain; ____

Any difficulty with **bonding**? □ Yes □ No

If yes, please explain; ____

Any **behavioral problems** or concerns? □ Yes □ No

If yes, please explain; ____

Any night terrors, sleepwalking or difficulty sleeping? □ Yes □ No

If yes, please explain; ____

How many hours of **sleep** does your child get per night? ____

At what age did they sleep through the night (5 hours)? ____

At what age did your child begin daycare? ____________________

How many hours of TV does your child watch per week?____________________

Are you concern at all with your **child's development** thus far? □ Yes □ No

If yes, please explain; ____

FAMILY HISTORY

Does your family have any of the following conditions?

□ Heart Disease □ Cancer □ Diabetes □ Depression
□ Back problems □ Liver disease □ High blood pressure □ High cholesterol
□ Lung problems □ Scoliosis □ Neck problems □ Osteoporosis
□ Seizures □ Rheumatoid Arthritis □ Other: ____

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, ______________________________, being the parent or legal guardian of __________________________
hereby grant permission for my child to receive further evaluation, and chiropractic care.
Signed ___________________________ **Date:** _______________**Witnessed** _______________________________