FAMILY WELLNESS CENTRE
DR. JON DIPLOCK, CHIROPRACTOR

PEDIATRIC HEALTH RECORDS

Date: _____

PERSONAL HEALTH HISTORY

Name: _____ Birth Date: _____/_____/_____ Age: _____ Gender ☐ M ☐ F
Parents/Guardians Name: _____Email_____
Address _____ City: _____ Province_____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Physician's Name: _____ Referred to our office by: _____

NATURE OF VISIT

☐ Wellness Check-up
☐Symptoms/Complaint_____
_____
Other Doctors seen for this condition: ☐ No ☐ Yes, if yes then who? _____
Type of treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐No
What aggravates the child's condition? _____
What relieves the child's condition? _____
Is it getting: ☐ Better ☐ Worse ☐ No change ☐ Comes and goes ☐ Constant
Please list any medications the child is currently taking: _____
_____

PRENATAL HISTORY

Who did the mother see for prenatal care: ☐ Midwife ☐ Obstetrician ☐ Other: _____
Were there any problems during pregnancy? ☐ No ☐ Yes: _____

BIRTH HISTORY

Labor: How long was the first stage (dilation to 10cm)? _____ Second stage (active pushing)?_____
Location of Birth: ☐ Home ☐ Hospital ☐ Midwife Clinic
Delivery Method: ☐ Vaginal ☐ Planned C-section ☐ Emergency C-section
Who delivered the baby? ☐ Midwife ☐ Obstetrician ☐ Other: _____
Was the birth assisted? ☐ No ☐ Yes: ◯ Induction ◯ Forceps ◯ Vacuum extraction
Type of presentation: ☐ Head (anterior or posterior) ☐ Face ☐ Breech

FEEDING & ELIMINATION HISTORY

For the child who is NOT consuming solid food yet:
How is the child feeding: ☐ Breast ☐ Bottle ☐ How often? _____
For the child consuming solid foods:
At what age were solid foods introduced? _____
Is feeding a pleasant experience for the mother and baby? ☐ Yes ☐ No
How would you describe the child's eating habits? ☐ Poor ☐ Good ☐ Excellent
How many wet diapers does the baby have per day? _____
How many soiled diapers does the baby have per day? _____

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SLEEPING HABITS & POSITIONS

What position does the baby sleep? ☐ Back ☐ Side ☐ Stomach
Are there any sleeping problems? ☐ No ☐ Yes: _____
How many hours does the baby sleep during the night? _____

CRYING HISTORY

Does the child experience excessive crying? ☐ No ☐ Yes
If YES, what is the: Number of hours/day: _____ Number of days/Week:_____
Has the child cried constantly for more than 2hrs? ☐ Yes ☐ No
Does the child appear weak to cry? ☐ No ☐ Yes

FAMILY HISTORY

Are there any conditions or diseases that run in your family: _____
Is there asthma or allergies in the family? ☐ No ☐ Yes
Are there pets in the home? ☐ Yes ☐ No Are there smokers in the home? ☐Yes ☐No

Has your child experienced any of the following?
☐ Accidents/Falls_____ Treatment? _____
☐ Asthma _____ Treatment? _____
☐ Colds _____ Treatment? _____
☐ Constipation _____ Treatment? _____
☐ Diarrhea _____ Treatment? _____
☐ Ear Infections _____ Treatment? _____
☐ Fevers _____ Treatment? _____
☐ Flu _____ Treatment? _____
☐ Headaches _____ Treatment? _____
☐ Leg/Growing Pains_____ Treatment? _____
☐ Meningitis _____ Treatment? _____
☐ Other _____

MILESTONES

At what age did the child:
First hold head up: _____ Walking:_____
Sitting: _____ Talking: _____
Crawling: _____ Toilet Trained: _____
Standing up: _____

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