Helping children have better health, and live life more Fully Alive Since 2005.

CONFIDENTIAL PATIENT HEALTH RECORD
CHILDREN **Date**

Patient Introduction

Personal History:

Patient Name: ________________ ______________________ ____________________________
First Middle Last

Mom and Dad's Names: ____

Address: ____

Telephone: Home: ________________ Other: _______________ Email: ________________

Birth Date: Day ______ Month ______ Year _______ Age _______

Previous Chiropractor: ____________________________ City: _____________________________

Last Adjustment: _________________________ Past Schedule of Care: __________________

Reason for Leaving: ____

Present MD: _____________________________________ City: ____________________________

How Did You Hear About Our Office?: ____

What Made You Choose to Come to Our Office?: ____

____

Child and Adolescent Health Questionnaire

This part is mainly for Moms:

1. Tell us about your pregnancy:

Did you carry full term? ___________________ If not, how many weeks gestation? _________

Describe any complications that occurred: ____

____

2. Tell us about your delivery and birth of your child: ________________________________

____

Did you use a midwife? ________ Hospital? _________ Obstetrician? ___________

Did you have a C– Section? _______ Were forceps used? ______ Vacuum extraction? _____

Were you induced? _______ Did you have an epidural? ______ Was it a difficult birth? _____

Were any drugs given to mom or baby during or after delivery? _________________________

What was the baby's **APGAR** score at 1 minute? ______ /10 at 5 minutes ________ /10

Was there initial respiratory delay? ________ Purple markings on face or neck? ___________

Misshapen head or skull? ____________________

3. Tell us More:

Did you breastfeed? ________ For how long? _________ What formula after? ___________

Did you consume alcohol, cigarettes, medications or other drugs during your pregnancy?

____________________ How Much ______________ How Long? ______________

Any exposures to ultrasound? _________ How many? _________

4. **As a baby/toddler, (birth to 4 years), did any of the following occur?**

Fall from a change table
Tumble down stairs
Fall out of a crib
Involved in a car accident
Fall off playground equipment
Play in "Jolly Jumper"
Frequent ear infections
Tonsillitis
Reaction to vaccination
Frequent crying spells
Frequent fevers
Frequent bouts of diarrhea
Constipation
Sleeping problems
Frequent colds
Colic
Did not gain weight
Other ______________________________

Please explain the above: ____
____
____

5. **As a young child, (5-12 years), did any of the following occur?**

Fall from a tree
Fall of a bicycle
Fall off playground equipment
Sports accident
Stomach pains
Scoliosis
Bed wetting
Hyperactivity/Autism
Learning difficulties
Asthma
Leg/knee pains
Other ______________________________

Please explain the above: ____
____
____

6. **Tell us about any vaccinations your child has had:**

____
____

Any reactions to any of these? ____

7. **As a child or adolescent, has your child experienced any of the following:**

Headaches
Dizziness
Ringing in ears
Asthma
Hyperactivity
Fatigue
Numbnesss in arms/hands
Arm/wrist pains
Sleeping problems
Allergies
Stomach problems
Weight gain/loss
Foot/ankle/knee pains
Tingling in arms/legs
Neck/back pains
Shoulder pains
"Growing Pains"
Other ___________________

Please explain the above: ____
____
____

8. **Which of the problems you have checked off is the worst?** ____________________________

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic __

9. **How long has it persisted?** ____________________________

10. **When it is at its worst, how does it make you feel?** ____________________________

____

11. **What have you done about it that has NOT worked?** ____________________________

____

____

12. **What makes it worse?** ____________________________

13. **What effect does this problem have of your child's body functions?** ____________________________

____

On his/her participation in daily activities?____________________________

14. **Describe any hospital stays:** ____________________________

____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?**

____

____

16. **List any medications your child is currently taking:** ____________________________

____

17. **To summarize, what is your purpose for this appointment?** ____________________________

____

____

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____

18. **Is there anything else you feel we should know?** ____________________________

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____________________________ (Signature of Parent or Guardian)

____________________________ (Date)

Thank You!