Imagine Chiropractic
The Kids Chiropractor

Pediatric Patient History

TODAY'S DATE _____

CHILD'S NAME_____ **DATE of BIRTH** ____/____/_____
Last first middle

ADDRESS:_____CITY_____STATE_____ZIP_____

MOTHER'S NAME_____ FATHER'S NAME_____
Last first Last first

MOTHER'S OCCUPATION_____FATHER'S OCCUPATION_____

EMAIL:_____MOTHER'S CELL_____FATHER'S CELL _____

AGE_____ BIRTH WEIGHT_____ CURRENT WEIGHT_____ SEX M F NUMBER of SIBLINGS_____

Have any of the SIBLINGS seen a Chiropractor? YES/NO If Yes, Where:_____

OBSTETRICIAN / MIDWIFE _____
Name Located at

PEDIATRICIAN / FAMILY MD_____
Name Located at

DATE OF LAST VISIT TO MD_____ PURPOSE_____

What are your chief concerns if any with your child's health or reason for contacting us?
_____

List any other care your child has undergone with regards to this complaint including medication: _____
_____

Date of Onset___/___/___ Onset was: (circle) Sudden------Gradual------- Associated with an event

Duration of Problem or episodes: (circle) Minutes---Hours----Days----Months----Years

Pattern of Problem : (circle) Constant-----Intermittent-----Occasional-----Cyclical
Initiating factors:_____
Aggravating factors:_____
Relieving factors:_____
How does the problem affect your child's body function and daily activities?_____
_____
Other health concerns:_____

HISTORY OF BIRTH

Hospital / Birthing Center: Home Medical Midwife Duration of Gestation _____

Was the birth assisted? Yes No If yes, how? Forceps Vacuum Extrc. C-Section Induced Labor

Were medications given to the mother at birth? Yes No If yes, what?_____

Duration of Birth (total time) _____ Labor(hrs.)_____ Pushing (min/hrs) _____

Was the delivery normal? No Yes If no, what complications were there at birth?_____

APGAR at birth_____/_____ Birth Weight_____ Birth Length_____

Was there a presence of : _____JAUNDICE (yellow)_____CYANOSIS (blue)_____CONGENITAL ANOMOLIES

Please fill ALL information in completely as possible.

GROWTH AND DEVELOPMENT

Was the infant alert & responsive within 12 hours after delivery? Yes/ No If no, explain_____
_____

AT WHAT AGE DID THE CHILD:
_____Respond to sound _____Follow an object with his/her eyes _____Hold head up _____Crawl _____Sit alone
_____Stand _____Walk alone _____Teethe
Do his/her sleep patterns seem normal Yes/ No
NO. OF HOURS SLEEP PER NIGHT:_____ NO. OF NAPS_____ QUALITY OF SLEEP: GOOD____ FAIR____POOR____

Describe any health problems that exist on the mother's and father's side of the family? (e.g. Cancer, Diabetes etc)_____

_____

Do the child's siblings have any health problems? Yes/ No If yes, describe_____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors During pregnancy did the mother: 1. Smoke? Yes/ No 2. Drink alcohol? Yes/No

3. Take Supplements/vitamins Yes /No 4. Take Drugs? Yes/ No If yes, what?_____

5. Become ill? If so, how? _____ 6. Receive ultrasounds? Yes/ No If yes how many?_____ 7. Receive invasive procedures (ie. Amniocentesis, CVS) Yes/ No Was your child breast fed? Yes/ No If yes, for how long?_____ Wks/Months/Yr

At what **age** was: 1a.Formula introduced?_____ b. Brand?_____ 2. Cow's milk_____ 3. Solid foods_____

Did your child receive vaccinations? Yes/ No If yes, which ones?_____Did your child react to them Yes/No

Has your child had antibiotics? Yes/ No If yes how many courses has the child had so far and why?_____

Any pets at home? Yes/No Any smokers at home Yes/No If yes, how much?_____

Psychological Stressors Any difficulties with Lactation? Yes/No Any problems bonding? Yes/No

Does your child seem normal to you? Yes/No Does the child have any behavior problems? Yes/No

If Yes, What _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.) Yes/No If yes, specify:_____

Did or Does your child go to daycare? Yes/ No From what age?_____ Average number of hours of TV/Computer/Electrontics per week? _____hrs

Traumatic Stressors Any evidence of trauma during birth? Bruises Odd shaped head Stuck in birth canal Fast and /or excessively long birth Respiratory distress Cord around neck Other _____

Any falls/accidents during pregnancy? Yes/ No Has the child had any major falls since birth? Yes/ No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? Yes/ No Please explain: _____

Does your child play sports? Yes/No Number of hours per week? _____ Age child began_____yrs

Weight of school backpack?_____lbs approximate. Approx hours spent at play per week?_____hrs__

HAS THE CHILD EVER SUFFERED FROM: (check those that apply past or present)

Dizziness	Backaches	Heart Trouble	Chronic Earaches
Diabetes	Tuberculosis	Hypertension	Colds/Flu
Arthritis	Headaches	Asthma	Allergies
Neuritis	Digestive Disorders	Sinus Trouble	Constipation
Anemia	Rheumatic Fever	Orthopedic Problems	Diarrhea
Poor Appetite	Hyperactivity	Sugar Concentration	Behavioral Problems
Bed Wetting	Convulsions	Paralysis	Muscle Jerking
Fainting	Walking Problems	Broken Bones	Ruptures/Hernias
Neck Problems	Arm Problems	Leg Problems	"Growing Pains"
Torticollis	Joint Problems	Blood Disorders	Stomach Aches

For doctor to fill out below
PRESENT HISTORY: _____
SURGERY:_____
MEDICATIONS:_____
ACCIDENTS:_____
FAMILY HISTORY:_____