Pediatric Health History

In order to provide you the best wellness care, please complete this form in its entirety. All information is strictly **CONFIDENTIAL.**

Donohoe Chiropractic, Inc.

PATIENT INFORMATION

TODAY'S DATE | NAME | ○ Male ○ Female | AGE | BIRTH DATE

ADDRESS | CITY

STATE | ZIP CODE | HOME PHONE | CELL PHONE

EMAIL ADDRESS

**Your email will not be shared with any 3rd parties, and is used for occasional office announcements and promotions.*

PRIMARY PHYSICIAN/PEDIATRICIAN | OFFICE PHONE NUMBER | If your doctor did NOT refer you to our clinic, can we send a summary of this visit to your doctor? ○ Yes ○ No

Whom may we thank for referring you to our office today? | Would you like to Opt In for Text Message Appointment Reminders? ○ Yes ○ No

FAMILY INFORMATION

MOTHER'S NAME | PRIMARY/HOME PHONE | SECONDARY WORK/CELL PHONE

FATHER'S NAME | PRIMARY/HOME PHONE | SECONDARY WORK/CELL PHONE

PARENT'S MARITAL STATUS ○ Married ○ Single ○ Divorced ○ Widowed | Does one or both parents have custody? ○ Both ○ Mother ○ Father

NAMES & AGES OF OTHER CHILDREN IN THE FAMILY:

EMERGENCY CONTACT INFORMATION

IN AN EMERGENCY CONTACT: | RELATIONSHIP

HOME PHONE | WORK PHONE | CELL PHONE

ACCOUNT INFORMATION

NAME OF PARTY RESPONSIBLE FOR PAYMENT | RELATIONSHIP

BILLING ADDRESS | CITY

STATE | ZIP CODE | HOME PHONE | DRIVERS LICENSE #

SOCIAL SECURITY # | PAYMENT METHOD ○ Cash ○ Check ○ Credit Card ☐ VISA ☐ MasterCard ☐ ☐ DISCOVER ☐ ATM

CREDIT CARD NUMBER | EXPIRATION DATE | CCV CODE

I understand that outstanding balances of more than 30 days will be charged to this account. CARD HOLDER'S SIGNATURE _____ DATE _____

CONSENT TO EVALUATE & TREAT A MINOR

I, being the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request Donohoe Chiropractic and/or Doctor(s) of this clinic to administer such treatment deemed advisable, including but not limited to examinations, radiological exams, and/or treatment. I agree that I will be responsible for any bill incurred on behalf of the above named individual.

A photocopy of this form associated signature(s) shall be considered as effective and valid as the original.

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

TYPE OF CARE DESIRED

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

◯ **RELIEF** ◯ **CORRECTION OF THE CAUSE** ◯ **PREVENTION** ◯ **LET THE DOCTOR DECIDE**

LEARNING, DEVELOPMENTAL & SCHOOL

CHILD'S CURRENT GRADE LEVEL	NUMBER OF SCHOOLS ATTENDED	Is your child home-schooled? ◎ Yes ◎ No Does your child enjoy school? ◎ Yes ◎ No

SPECIFIC LEARNING DISABILITIES

ACADEMIC STRENGTHS

HOW IS YOUR CHILD DOING IN SCHOOL?

DRUG/ALCOHOL HISTORY

NUTRITION HISTORY *Please describe a typical day's diet for your child:*

BREAKFAST	**LUNCH**
DINNER	**SNACKS**
FAVORITE FOODS	**ARE THERE ANY FOODS THAT YOUR CHILD "LOVES" OR "CRAVES"?**

How many cups of the following does your child drink?	WATER	JUICE	SODA	COW'S MILK	OTHER DRINKS

IMMUNIZATIONS & ANTIBIOTICS

Is your child fully immunized? ◯ Yes ◯ No

If not, please check the vaccines your child has had:

☐ **MMR** *(Measles Mumps Rubella)* ☐ **Hib** *(Haemophilus)* ☐ **Varicella** *(Chicken Pox)* ☐ **DTaP** *(Diphtheria Tetanus Pertussis)* ☐ **IPV** *(Polio)*

☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **Influenza** ☐ **HPV** *(Cervical Cancer)* ☐ **Meningococcus** *(Meningitis)* ☐ **Others**

Do you think there was any relation between timing of the vaccines and development of any of the health concerns you may have?
◯ Yes ◯ No *(If yes, please explain)*

Approximately how many antibiotics has your child had (total life)?	How many antibiotics did your child receive in one year (worst year)?

MEDICATIONS & SUPPLEMENTS

CURRENT PRESCRIPTION MEDICATIONS:

CURRENT VITAMINS, HERBS & SUPPLEMENTS:

MEDICATIONS YOUR CHILD IS ALLERGIC TO:

SLEEP HABITS

How many hours per night does your child sleep?	Naps (number & length)

Trouble falling asleep? ◯ Yes ◯ No Trouble staying asleep? ◯ Yes ◯ No

Any sleep problems? ◯ Yes ◯ No *(If yes, please explain)*

Sleep Behaviors *(Please check all that apply)* ☐ **Sleepwalking** ☐ **Nightmares** ☐ **Recurrent Dreams**

BIRTH & INFANT HISTORY

MEDICATIONS DURING PREGNANCY

Did you have gestational diabetes? ◯ Yes ◯ No | Did you require antibiotics prior or during delivery? ◯ Yes ◯ No | Were you induced? ◯ Yes ◯ No

GESTATION PERIOD (IN WEEKS):	DURATION OF LABOR (IN HOURS):	TYPE OF BIRTH ◯ Vaginal ◯ C-Section	DURATION OF BIRTH (IN HOURS):	APGAR SCORE	BIRTH WEIGHT

Assistance during birthing? ☐ **Vacuum** ☐ **Forceps** | Was your child: ☐ **Breech** ☐ **Side Lying**

COMPLICATIONS DURING BIRTH	BIRTH INJURIES

Did your child have any of the following problems shortly after birth? ☐ **Birth Injuries** ☐ **Blue Baby** ☐ **Cerebral Palsy** ☐ **Seizures** ☐ **Jaundice**
☐ **Other** *(Please explain)*

BIRTH & INFANT HISTORY (CONT.)

Did your child have: COLIC? ◯ Yes ◯ No

REFLUX? ◯ None ◯ Mild ◯ Moderate ◯ Severe

POSSIBLE MILK OR SOY ALLERGY AS AN INFANT? ◯ Yes ◯ No

Was your child breast fed? ◯ Yes ◯ No For how long?

Was your child fed formula? ◯ Yes ◯ No What type? ◯ Milk ◯ Soy ◯ Other:

HEALTH INFORMATION

PURPOSE OF THIS APPOINTMENT

When did this condition begin?

Other Doctor(s) seen for this condition? ◯ Yes ◯ No *If yes, who?*

TYPE OF TREATMENT(S):

RESULTS:

MEDICATION(S):

MAJOR SURGERIES/OPERATIONS:

MAJOR ACCIDENTS OR FALLS:

Previous Chiropractic Care? ◯ Yes ◯ No

DOES YOUR CHILD SUFFER FROM: *(Please check all that apply)*

- ☐ Allergies *(please list)*
- ☐ Asthma
- ☐ Bladder Trouble *(bed wetting, infection)*
- ☐ Chest Congestion/Coughs
- ☐ Chicken Pox
- ☐ Constipation
- ☐ Convulsions
- ☐ Dizziness
- ☐ Ear aches/Infections
- ☐ Frequent Colds
- ☐ Headaches *(How often?)*
- ☐ Heart Disease
- ☐ Measles
- ☐ Mumps
- ☐ Pain *(Please describe)*
- ☐ Walking/Movement Problems *(Please describe)*