PEDIATRIC HEALTH HISTORY FORM

Today's Date: __________________

Child's Name: ____

Child's Age: _______________ DOB: _____________________ Gender: F / M

Parent Name(s): ____

Parent SSN: _________________________________ Parent DOB: _________________________

Sibling's Names & Ages: ____

Address: ____City: _________________ State: ______ Zip: ________________

Primary Phone: __________________________ Other Phone: _________________________

Family Doctor's Name: _______________________________________ Phone: ___________________________

Who may we thank for referring you? ____

Has your child ever received chiropractic care? *Yes* *No* If *Yes*, previous Chiropractor? ___________________________

Date of last visit: __________________ Reason for the last visit: ____

Other professionals seen for this condition: ____

Results with that treatment: ____

Recent tests done (list date beside): Bloodwork _____________ Urine _______________ X-Rays__________________

Other (explain): ____

Please circle the purpose for your child's visit (circle all that apply)*:*

Crisis Management *Early Detection of Problems* *Prevention* *Wellness*

Maximizing Normal Growth & Development *Other:* ___________________________________

Authorizing Consent for Examination of a Minor (under 18 years): Please read carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's/ guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: ____ Date: ___________________________

Signature: ____ Witness: ____

Doctor of Chiropractic: ____ Date: _____________________

Present Health Concerns

Major Problem(s): ______________________________

Minor Problem(s): ______________________________

When did the problem(s) begin? ______________________________

Is this problem (circle one): *Occasional* *Frequent* *Constant* *Intermittent*

Does problem radiate? *Yes* *No* If *Yes*, where? ______________________________

What makes problem worse? ______________________________

What makes problem better? ______________________________

Is the problem worse during a certain time of the day? *Yes* *No* If *Yes*, when? ______________

Does this interfere with the child's sleep? *Yes* *No* Eating? *Yes* *No*

Daily routine? *Yes* *No* Is this becoming worse? *Yes* *No*

Often seemingly unrelated symptoms can manifest as other health concerns. Please mark if your child has had any of the following:

- ☐ Headaches
- ☐ Dizziness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Loss of Balance
- ☐ Loss of Concentration
- ☐ Fainting
- ☐ Ears Buzzing
- ☐ Poor Coordination
- ☐ Vision Changes
- ☐ Loss of Memory
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Light Sensitivity
- ☐ Face Flushed
- ☐ Reduced Mobility
- ☐ Chest Pressure
- ☐ Breast Pain
- ☐ Frequent Colds
- ☐ Sinus Congestion
- ☐ Sore Throats
- ☐ Ear Pain/Infections
- ☐ Asthma
- ☐ Cold Sweats
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Urinary Problems
- ☐ Bloating/Gas
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Dental Problems
- ☐ Fevers
- ☐ Heart Palpitations
- ☐ Numbness in Feet
- ☐ Numbness in Hand(s)
- ☐ Weakness
- ☐ Heartburn
- ☐ Muscle Cramps
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Radiating Pain
- ☐ Sleeping Problems
- ☐ Numbness in Leg(s)
- ☐ Stiffness

Other: ______________________________

Birth History

What was the child's gestational age at birth? ________ weeks.

Birth Weight ________ lbs _____ oz Birth Length __________ inches Duration of birth _______ hours

Location of child's birth: *Home* *Birthing Center* *Hospital* *Other:* ______________

Was the birth considered: *Medical* or *Midwife* Was labor: *Spontaneous* or *Induced*

Was child born: *Cephalic (Head First)* *Breech (Feet First)*

Were there any complications? *Yes* *No* If *Yes*, please explain: ______________

Assistances used during delivery: *Forceps* *Vacuum Extraction* *C-section* *Episiotomy*

Were medications or epidurals given to mother during birth? *Yes* *No*

Is there anything else we need to know about the birth? *Yes* *No*

If *Yes,* explain: ______________________________

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? *Yes* *No*

If *No*, please explain: ______________________________

At what age did the child:

Respond to sound ____________ Follow an object ____________

Hold up head ____________ Vocalize ____________

Sit alone ____________ Teethe ____________

Crawl ____________ Walk ____________

Does your child sleep on his/her: *Front* *Back* *Side*

Do you consider the child's sleeping pattern normal? *Yes* *No* How many hours per day? ________

If *No*, please explain: ______________________________

Family Health History

Please note any health problems (ex. cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mother's Family: ______________________________

____

Father's Family: ______________________________

____

Siblings: ______________________________

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ex. falls, accidents, etc.) *Yes* *No*

If *Yes*, please explain: ______________________________

Any evidence of birth trauma to the infant?

Bruising *Odd Shaped Head* *Stuck in Birth Canal* *Fast or Excessively Long Birth*

Respiratory Depression *Cord Around Neck* *Other:* ______________________________

Any falls from couches, beds, change tables, etc? *Yes* *No*

If *Yes*, please explain: ______________________________

Any traumas resulting in bruises, cuts, stitches or fractures? *Yes* *No*

If *Yes*, please explain: ______________________________

Any hospitalizations or surgeries? *Yes* *No*

If *Yes*, please explain: ______________________________

Any sports played? ______________________________

Is a school backpack used? *Yes* *No* If *Yes,* is it *Heavy* or *Light*?

Chemical Stressors

Was this child breast-fed? *Yes* *No* If *Yes*, how long? ______________________________

Formula introduced at what age: ____________________ Which formula? ____________________________________

Introduction to cow's milk at what age: ________________ Began solid foods at what age: ______________________

Types of solid foods: ____

Food/Juice intolerance? *Yes* *No* Type: ____

Is your child on or taken any medications in the past? ____

During the mother's pregnancy:

Did the mother smoke? *Yes* *No* How much? ___________________________________

Drink alcohol? *Yes* *No* How much? ___________________________________

Any illnesses during the pregnancy? *Yes* *No* If *Yes*, describe: ____

Any supplements taken? *Yes* *No* If *Yes*, describe: ____

Any drugs taken? *Yes* *No* If *Yes,* describe: ____

Any ultrasounds? *Yes* *No* How many: ___________ Reasons for being done: ___________________________

Any invasive procedures during pregnancy (ex. Amniocentesis, Chorionic villi sampling, etc.)? *Yes* *No*

If *Yes*, please explain ____

Any pets at home? *Yes* *No* Type: ____

Any smokers in the home? *Yes* *No*

Any antibiotics given? *Yes* *No* If *Yes*, reason: ____

Is the diet organic? *Yes* *No*

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

Never *Rarely* *Few times per week* *Daily* *Nearly Each Meal*

Are you aware of the impact of nutrition on children's behavior? *Yes* *No*

Would you like information on nutrition for your child? *Yes* *No*

Psychosocial Stressors

Any difficulties with lactation? *Yes* *No* ____

Any problems with bonding? *Yes* *No* ____

Any behavioral problems? *Yes* *No* ____

Any inattention? *Yes* *No* ____

Any hyperactivity or restlessness? *Yes* *No* ____

Any compulsiveness? *Yes* *No* ____

Any difficulties at daycare or school? *Yes* *No* ____

Any challenges with learning deficiencies? *Yes* *No* ____

Any night terrors, sleep walking, difficulty sleeping? *Yes* *No* ____

Any prolonged temper tantrums or separation anxiety? *Yes* *No* ______________________________________

Is the child in daycare? *Yes* *No* ____

Age of child when began daycare? ____________________

Is there a nanny or regular sitter during the day if both parents work? *Yes* *No*

Is the child home schooled? *Yes* *No* By whom? ______________________________

Average number of hours of television per week? _________________________

Average number of hours of video games per week? _____________________________

Does your child have a cell phone? *Yes* *No* How often do they text or use the phone? ____________________

Do you feel that your child's social and emotional development is normal for their age? *Yes* *No*

____

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.