Pediatric Health History Form

Patient Information

Child's Name:_______________________ Parent(s)/Guardian(s) Names: ____________________________

Address:_________________________________ City____________________ State _______ Zip___________

Home Phone: ____________________ Work Phone:___________________ Cell Phone: __________________

Is it ok to contact you at work? ☐ Yes ☐ No

Child's Social Security # _____________________ Birthdate________________________ Child's Age:______

Email: ____

May we add you to our email newsletter? ☐ Yes ☐ No

Has your child ever received Chiropractic Care? ☐ Yes ☐ No

If yes, who is your child's previous Doctor of Chiropractic? ________________________________

What was the date and reason for previous visit? ____

Were you pleased with your care? ☐ Yes ☐ No

Is your child receiving care from other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty: ____

____

Who is your family's primary care physician?____

Clinic Name____________________________ Date & Reason for last visit__________________________

May we communicate with your family primary care physician regarding your child's care if necessary? ☐ Yes ☐ No

How did you find out about our office?____

Emergency Contact

Name:____ Relationship: ________________________

Phone:___________________________________ Alternate Phone: ____________________________________

Current Health

What health conditions bring your child to our office? ______________________________________

____

When did the symptoms first begin? ____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is the condition: ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Not Sure

What makes the problem better? ____

What makes the problem worse? ____

Has your child ever had a similar condition? ☐ Yes ☐ No

If yes, please explain: ____

Does your child eat well: ☐ Yes ☐ No

Does your child have regular bowel/bladder movements? ☐ Yes ☐ No

Has your child ever been checked for vertebral subluxation? ☐ Yes ☐ No

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

☐ Allergies	☐ Fatigue	☐ Poor Coordination
☐ Asthma	☐ Fevers	☐ Radiating Pain
☐ Behavioral Problems	☐ Frequent Colds	☐ Reflux
☐ Bloating/Gas	☐ Frequent Crying Spells	☐ Scoliosis
☐ Broken Bones	☐ Headaches/Migraines	☐ Seizures
☐ Bronchitis	☐ Irritability	☐ Shortness of Breath
☐ Colic	☐ Joint Problems	☐ Sinus Congestions
☐ Constipation	☐ Light Sensitivity	☐ Skin Irritation
☐ Depression	☐ Loss of Balance	☐ Sleeping Problems
☐ Diabetes	☐ Loss of Concentration	☐ Stiffness
☐ Diarrhea	☐ Loss of Smell	☐ Tonsillitis/Sore Throats
☐ Difficulty Breathing	☐ Loss of Taste	☐ Upper Back Pain
☐ Digestive Problems	☐ Low Back Pain	☐ Urinary Issues/Bedwetting
☐ Dizziness	☐ Muscle Pain	☐ Vision Changes
☐ Ear Buzzing	☐ Neck Pain	☐ Weakness
☐ Ear Pain/Infections	☐ Numbness	☐ Weight Gain/Loss
☐ Face Flushed	☐ Orthopedic Problems	☐ Other:
☐ Fainting	☐ Pneumonia	________________

Birth History

Child's birth was ☐ At Home ☐ At a Birthing Center ☐ At a Hospital

My ob/midwife/family physician was ____

Child's Birth was ☐ Natural vaginal (no medications/interventions)

☐ Vaginal with interventions

☐ Induction ☐ Pain Medication

☐ Epidural ☐ Vacuum Extractions ☐ Forceps

☐ C-Section

☐ Scheduled ☐ Emergency

Please list reasons for any interventions/complications ____________________________________

____

Medications during labor/delivery ______________________________

Child's birth weight ________ Child's birth height ________

Current weight ________ Current height ________

APGAR score at birth ________ APGAR score after 5 min ________

Anything else we need to know about this birth? ☐ Yes ☐ No

If yes, please explain ______________________________

Growth & Development

Was your child 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 head up ________ Vocalize ________

Sit alone ________ Teethe ________ Crawl ________ Walk ________

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations including the year) ______________________________

____

Please list any major injuries, accidents, falls, and fractures your child has sustained in his/her lifetime (including the year)______________________________

____

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long? ________

Formula introduced at age ________ What type? ________

Introduction of cow's milk at age ________ Began solid food at age ________

Please list any food/juice intolerance ______________________________

Did mother smoke during pregnancy? ☐ Yes ☐ No

Did mother drink alcohol during pregnancy? ☐ Yes ☐ No

Any illness of mother during pregnancy? ☐ Yes ☐ No

If yes, please explain including treatment/medications/supplements ________

____

List any drugs/medications (including over the counter) taken during pregnancy ________

____

List any supplements taken during pregnancy ______________________________

Any exposure to ultrasound? ☐ Yes ☐ No

If so, how many and what was the medical reason ______________________________

Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No

Has child received any vaccinations? ☐ Yes ☐ No If yes, which ones and list any reactions ______

____

Has child received any antibiotics? ☐ Yes ☐ No If yes, how many times and list reason _______

____

Any difficulty with breastfeeding? ☐ Yes ☐ No If yes, please explain ________________________

____

Any difficulty with bonding? ☐ Yes ☐ No If yes, please explain ________________________

____

Any behavioral problems? ☐ Yes ☐ No If yes, please explain ________________________

____

Any night terrors, sleepwalking, or difficulty sleeping? ☐ Yes ☐ No

If yes, please explain ____

Age child began daycare _________ Average number of hours TV per week ____________________

Please list any drugs or medications your child is taking:__________________________________

____

Please list any vitamins/hers/homeopathics/other that your child is taking: ________________________

____

Please list any allergies your child has: ____

____

Does your child have a preferred sleeping position? ☐ Yes ☐ No

____

Does your child sleep the entire night? ☐ Yes ☐ No

____

Has your child ever fallen from any high places? ☐ Yes ☐ No

If yes, please explain ____

Does your child seem developmentally appropriate for their age? ☐ Yes ☐ No

If no, please explain ____

Family History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart conditions, hypertension…) that are present in:

Mothers Family: ____

Fathers Family: ____

Siblings: ____

Chiropractic

Do you know what a subluxation is? ☐ Yes ☐ No

Do any of your friends or relatives see a chiropractor? ☐ Yes ☐ No

If yes, do they use chiropractic for ☐ Health maintenance ☐ Health problems ☐ Both

Are you seeking chiropractic for ☐ Health maintenance ☐ Health problems ☐ Both

What would you like to gain from chiropractic care? ______________________________

____

What is your primary goal for your child at our clinic? ______________________________

____

Are there other health concerns or anything else you'd like us to know about your child?

____

____

______________________________ ______________________________

Parents/Guardians signature **Date**