Pediatric Health History

PERSONAL INFORMATION

Name: _____ Preferred Name: _____ Date: _____

Birthday (MM/DD/YR): _____ Age: _____Gender: M or F

Address: _____

City / State / Postal Code: _____

Home #: _____ Cell #: _____Work #: _____

E-Mail Address: _____

Mother's name: _____ Father's name: _____

Sibling Age: ____Gender: M / F Sibling Age: ____ Gender: M / F

Who may we thank for referring you to our office?

□ Family/ Friend (name)_____ □ Website/Facebook (circle one)

□ Workshop (which one)_____ □ Walk-in

□ Health Practitioner_____ □ Print Advertisement_____

□ Other_____

CHIROPRACTIC HISTORY

Has your child ever been to a chiropractor before? __No __Yes Date of last visit:

Has a family member previously seen a chiropractor? __No __Yes if yes, Parent__Sibling__Child__

Name of chiropractor: _____

Reason for seeing them: _____

Describe your experience? _____

How frequently did you go for adjustments? _____

What made you decide not to return to see them? _____

HEALTH TEAM

Name of Obstetrician / Midwife: _____

Name of Pediatrician/Family MD: _____

Naturopath Other: _____

PREGNANCY HISTORY

Were any supplements taken during the pregnancy? __No __Yes _____

Medications taken during pregnancy (Presc. or over the counter) __No __Yes _____

During the pregnancy did the mother:

Smoke? __No __Yes How much? _____

Drink? __No __Yes How much? _____

Any ultrasounds or other radiation? __No __Yes

If so, how many and for what reasons? _____

Were there any invasive procedures during the pregnancy (amniocentesis, CVS etc.)? __No __Yes

Please explain: _____

Trauma/ illness during pregnancy: _____

Please describe any emotional stress the mother experienced during the pregnancy:

_____

Labor and Birth History

Position during labor: __On back __Side __Sitting __Standing

Was labor induced? __No __Yes

Did the mother have an episiotomy? __No __Yes

Was monitoring used? __Internal __External

Location of birth? __Home __Hospital __Birthing center

Birth assistants? __Midwife __Doula __Medical __Doctor __None

How many hours did labor last? _____ Birth weight_____ Birth length_____

Was the mother administered any drugs? __Epidural __Morphine __Other_____

Was there any assistance used during birth? __No __Yes: __Forceps __Caesarean __Vacuum extraction

Was there any evidence of birth trauma to the infant? Check all that apply:

__Bruising __Odd shaped head __Stuck in birth canal

__Fast or excessively long birth __Respiratory depression __Cord around neck

Were there any other complications during birth or congenital anomalies/ defects present? __No __Yes

Please explain: _____

MEDICAL HISTORY

Has your child been vaccinated? __No __Yes if yes, please list: _____

Did you notice any negative reactions? __No __Yes _____

History of antibiotics? __No __Yes Why? _____

Which ones and how many rounds? _____

Has your child taken prescription medications? __No __Yes Why? _____

Which ones and how many times? _____

Has your child taken over-the-counter medications? __No __Yes Why? _____

Which ones and how many times? _____

Has your child had any surgeries? __No __Yes Why? _____

GROWTH AND DEVELOPMENT

Was child breast-fed? __No __Yes For how long? _____

Difficulties with lactation: __No __Yes

Was Formula introduced? __No __Yes Why? _____

Was cow's milk introduced? __No __Yes At what age? _____

Have solid foods been introduced? __No __Yes At what age?__ 1st foods _____

Food intolerance? _____

Quality of Sleep: __Good __Fair __Poor Number of hours _____

Did your child favor turning their head to one side while sitting, sleeping or nursing? __No __Yes (Left/Right)

At what age did your child start: Roll Over_____ Crawl_____ Walk_____

Describe any complications or delays you noticed: _____

Any falls from couches, beds, change tables, etc...? __No __Yes _____

Any complications or delays noticed with speech development: _____

HEALTH CONCERNS

Please check (√) all that he/she has experienced in the last 12 months:

□ ADD/ADHD	□ Allergies/	□ Asthma	□ Autism Spectrum
□ Back Pain (Upper/Mid/Low)	□ Bedwetting	□ Behavior Issues	□ Cancer
□ Colic	□ Constipation	□ Cramps	□ Depression/Anxiety
□ Diabetes	□ Diarrhea	□ Dizziness/ Vertigo	□ Ear Infections/Aches
□ Epilepsy/Seizure	□ Feeding Difficulty	□ Headaches/ Migraines	□ Heart Conditions
□ Neck/Shoulder Pain	□ Pneumonia/Bronchitis	□ Respiratory Issues	□ Sensory Processing
□ Skin issues	□ Sleep Problems	□ Speech Development	□ Throat issues
□ Urinary Tract Infection	□Walking Development	□ Other: _____	

Fill out all detail below for the **3 most concerning conditions** that you checked off on the last page:

#1:

On a scale of 1-10 (10 being severe), how significant is the problem? ___/10

When did it start? _____ How? _____

Is it? __getting better __getting worse __staying the same

Describe the problem? _____

Are you taking medication for this condition? __No __Yes Please List: _____

#2:

On a scale of 1-10 (10 being severe), how significant is the problem? ___/10

When did it start? _____ How? _____

Is it? __getting better __getting worse __staying the same

Describe the problem? _____

Are you taking medication for this condition? __No __Yes Please List: _____

#3:

On a scale of 1-10 (10 being severe), how significant is the problem? ___/10

When did it start? _____ How? _____

Is it? __getting better __getting worse __staying the same

Describe the problem? _____

Are you taking medication for this condition? __No __Yes Please List: _____

Special Note: Have you taken any medication within the last 24 hours? __No __Yes

Please List: _____

Please check (√) what parts of life this is interfering with:

__School __Sleep __Play __Hobbies

__Exercise __Positive mental attitude __Other

Which part of life is most important to get back to ASAP? _____

Beyond feeling better, what are the top 3 goals for getting healthier?

1)_____

2) _____

3) _____

Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically for children of all ages. The risk of injuries and complication is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

- Research shows that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.
- While extremely rare, there have been reports of ligament sprains and rib fractures.

I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.
I understand that research is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes. (Your full name will not be used).
I consent to the care recommended by my Chiropractor.

Child's name: _____ Parent/ Guardian: _____

Signature: _____ Date: _____