Pediatric Health History

Child's Full Name_____ Today's Date_____
Address_____City_____State_____Zip_____
Birthdate_____Age_____Parent's Names_____
Mother's Home Phone_____Cell _____ Email_____
Father's Home Phone _____Cell _____ Email_____
Has any family member been a patient here? Yes ☐ No ☐ Names_____
Has this patient had any previous chiropractic care? Yes ☐ No ☐ Dr._____ Date:_____
Primary Care Physician_____ Last Visit_____ Reason_____

Reason For Visit

Please describe your child's ***major complaint***:

_____

Date Started___/___/___ Had before? Yes ☐ No ☐ Explain:_____
Secondary complaint_____
Date Started___/___/___ Had before? Yes ☐ No ☐ Explain:_____
Are any conditions interfering with: Sleep School Daily Routine Sports Other _____

Birth History

Delivery Method (check all that apply): ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum ☐ Epidural ☐ Induced ☐ Breech ☐ Back Birth

Location of Birth: Hospital ☐ Birthing Center ☐ Other ☐ _____

Chiropractic care during the pregnancy? Yes ☐ No ☐ Details_____
Any complications during pregnancy? Yes ☐ No ☐ Details_____
Medications/Drugs during? Yes ☐ No ☐ List_____
Cigarette/Alcohol use during? Yes ☐ No ☐ Explain_____
Any known congenital anomalies or defects? Yes ☐ No ☐ Explain_____

Health History

Breast fed? Yes ☐ No ☐ How Long?_____
Formula fed? Yes ☐ No ☐ How Long?_____Brand_____
Milk in a bottle? Yes ☐ No ☐ How Long?_____Kind of milk_____
Food or other allergies? Yes ☐ No ☐ List_____
Has your child ever taken antibiotics? Yes ☐ No ☐ Explain_____
Any prescription medication? Yes ☐ No ☐ Explain_____
Any vitamins or supplements? Yes ☐ No ☐ Explain_____
Has your child ever had surgery? Yes ☐ No ☐ Explain_____
Emergency Room visits? Yes ☐ No ☐ Explain_____
Vaccinations up-to-date? Yes ☐ No ☐ Explain_____

Age Development: Rolled over_____ Sat Up_____ Crawled_____ Walked_____ Talked_____
Have you ever been concerned your child was not developing and achieving normal milestones? Yes ☐ No ☐
Explain_____

Review of Systems

Mark with **N** if your child has the condition now; **P** if he/she has suffered from it in the past.

____Fever	____Colic	____Croup	____Learning Disorders	____Poor Posture
____Nervousness	____Constipation	____Bed-Wetting	____Weakness/Fatigue	____Allergies
____Sinus Trouble	____Stomachache	____Loss Of Hearing	____Ear Infections	____Arthritis
____Numbness	____Irritability	____Headache	____Neck Ache	____Backache
____Sore Throat	____Eye Problems	____Cough	____Skin Disorders	____Asthma
____Wheezing	____Scoliosis/Curvature	____Bronchitis	____Frequent Colds	____Muscular Dystrophy
____Cerebral Palsy	____Poor Concentration	____Arm/Hand Pain	____Painful Joints	____Hip/Foot Pain
____Shoulder Pain	____Clumsiness	____Foot Turned In/Out	____One Leg Shorter	____Headaches
____Neurological	____Autism	____Lack Of Focus	____Difficulty In School	____Overweight/Obesity

Health Habits

Please check any of the habits that your child has:

____Junk/Processed Food	____Aversion To Vegetables	____Has Breakfast Daily
____Soda/High Sugar Drinks	____Diet Drinks	____Adequate Water Intake
____High Activity Level/Exercise	____Low Activity Level/Sedentary	____High Impact Sports
____Excessive Computer Use	____Excessive Television/Video Games	____Trouble Sleeping

Favorite Foods_____

Typical Breakfast_____

Typical Lunch_____

Typical Dinner_____

Patient Trauma History

Any falls during the first year (i.e. from a bed, changing table, down the stairs, etc.) Yes ☐ No ☐

Explain_____

Has your child ever been involved in any high-impact sports or contact-type sports (i.e. football, soccer, gymnastics, hockey, basketball, martial arts, etc.)? Yes ☐ No ☐

Explain_____

Has your child ever been involved in an automobile accident? Yes ☐ No ☐ Date_____

Explain_____

Any residual health complications related to accident? Yes ☐ No ☐

Any additional falls or traumas or health issues not yet listed?

_____

Family History

Please mark family history of the below conditions using the following key:

M=Mother **F**=Father **S**=Sibling

_____Allergies	_____Asthma	_____Cancer
_____Heart Condition	_____High Blood Pressure	_____Mental Illness
_____Scoliosis	_____Kidney Disease	_____Liver Disease
_____Depression	_____Stroke	_____Overweight/Obesity
_____Skin Conditions	_____Diabetes	_____Other_____

I agree to be financially responsible for any charges and I also authorize treatment for this minor:

Parent Signature_____Date_____