Pediatric Health History (Ages 1-3)

Thank you for choosing chiropractic care for your child. Please complete this form in ink and print clearly. If you have any questions, do not hesitate to ask for assistance.

Child's Name:____________________Age:______Date of Birth:__________

Address:____

Mother's Name: ____________________Email:____________________

Home Phone:______________Cell:______________Work:______________

Father's Name:____________________Email:____________________

Home Phone:______________Cell:______________Work:______________

Person responsible for child's account:____________________Relation:__________

Who may we thank for referring you to our office?____________________

Insurance Information

Name of insured:______________________________Relation: __________

Insured Birth Date:____________________Social Security# ______________

Insurance Company:____________________Phone: ______________

Insurance Policy #____________________Group#______________

Insurance Co. Address:____

Medical Pediatrician:____________________Date of Last Visit:__________

Address of Pediatrician:____

Phone Number:____________________Dr.'s Assistant:______________

Other Doctor:____________________Phone:______________

Other Doctor:____________________Phone:______________

May we share your child's health history and exam with these doctors? ❒ Yes ❒ No

Family Medical History

Please check if any biological relatives to your child had any of the following illnesses and indicate which relative by noting: M (Mother), F (Father), S (Sibling), PGM (Paternal Grandmother), PGF (Paternal Grandfather), MGM (Maternal Grandmother), or MGF (Maternal Grandfather)

______Asthma or Allergies
______Cancer
______Diabetes or Low Blood Sugar
______Heart Trouble
______High Blood Pressure/Stroke
______Kidney Disease
______Neck or Back Pain
______Headaches
______Arthritis/Joint Pain
______Scoliosis
______Nervous System Disorders
______Liver Disease

Other: ____

Have any of your other children been diagnosed with any health problems?

Name:____________________Age:________Sex:_________Health status:_________________________

Name:____________________Age:________Sex:_________Health status: _________________________

Name:____________________Age:________Sex:_________Health status:_________________________

Which areas were affected by the mother during pregnancy:

❒ Headaches ❒ Neck Pain ❒ Midback Pain ❒ Lower Back Pain
❒ Numbness/Tingling in Arm/Hand ❒ Numbness/Tingling in Leg/Foot ❒ Muscle Weakness
❒ Other: ____

Labor & Delivery

Duration of pregnancy:_________________________Premature Delivery (how long):_________________

Duration of labor:______________________________❒ Vaginal ❒ Induced ❒ Cesarean

Delivery Complications: ❒ Epidural ❒ Forceps ❒ Suction cup ❒ Other:_______________________

Incubation Duration:____

Please check any problems your child has recently experienced:

❒ Difficulty Nursing ❒ Trouble Sleeping ❒ Excessive Crying ❒ Irregular Breathing ❒ Coughing

Other Issues:____

Medications:____

Surgeries:____

Does your child experience any of the following conditions:

❒ Right Ear Infection ❒ Currently ❒ Last episode ____________________
❒ Left Ear Infection ❒ Currently ❒ Last episode ____________________

What treatment(s) has your child received? ❒ Antibiotics ❒ Ear Tubes ❒ Other: _____________

Which treatment resolved the situation? ____

❒ Which vaccines has your child received?____

❒ Has your child had any adverse drug or vaccine reactions? ❒ Yes ❒ No

Which drugs/vaccines caused the reaction(s):____

❒ Has your child ever been rendered unconscious or had a convulsion or seizure?__________________

❒ Problems with the eyes or vision? ❒ Currently ❒ Last episode__________________________

❒ Problems with hearing? ❒ Currently ❒ Last episode__________________________

❒ Problems with speech? ❒ Currently ❒ Last episode__________________________

❒ Problems with breathing or asthma? ❒ Currently ❒ Last episode__________________________

❒ Allergies (ie: hay fever, dust, hives) ❒ Currently ❒ Last episode__________________________

❒ Skin, hair, nail or tooth problems? ❒ Currently ❒ Last episode__________________________

❒ Stomach issues (pain, vomiting, etc) ❒ Currently ❒ Last episode__________________________

❒ Bowel issues (diarrhea, constipation) ❒ Currently ❒ Last episode__________________________

❒ Does your child's stool look or smell abnormal? ❒ Currently ❒ Last episode_________________

❒ Unusual urination frequency/smell/appearance? ❒ Currently ❒ Last episode_________________

Does your child move normally and play without difficulty? ❒ Yes ❒ No _________________

Does your child limp or have an unusual gait pattern? ❒ Yes ❒ No _________________

Does your child complain of any head, neck or back pain? ❒ Currently ❒ Last episode____________

Does your child complain of pains in their arms and/or hands? ❒ Currently ❒ Last episode__________

Does your child complain of pains in their legs and/or feet? ❒ Currently ❒ Last episode___________

What aspects of your child's health or behavior would you like improved? _______________________

____

Nutrition

How many times each day do you breast feed your child? ____________________ ❒ Not Applicable

Do you use commercial feeding formula? ❒ No ❒ Yes, and breast milk ❒ Exclusively ❒NA

Do you feed your child: ❒ Home-made vegetables ❒ Home-made fruits ❒ Home-made cereals

❒ Commercial jar baby food ❒ Box cereals ❒ Other: ________________________________

Which beverages does your child mostly drink? ❒ Water ❒ Cow Milk ❒ Soy Milk ❒ Fruit Juice

Does your child have any food allergies? ❒ Yes ❒ No Please list:____________________________

Has your child been tested for food allergies? ❒ Yes ❒ No When?___________________________

Is your child currently on a restricted food diet? ❒ Yes ❒ No How Long?______________________

Chiropractic Care

Have you ever been to a chiropractor? ❒ Yes ❒ No When?_____________________________

Has your child ever been to a chiropractor? ❒ Yes ❒ No When?_____________________________

What do you want to achieve with chiropractic care for your child (and your family)?

❒ Increase overall health and wellness

❒ Decrease and eliminate symptoms

❒ Prevent future symptoms from re-occurring

❒ Improve heart/circulation functioning

❒ Improve lung/breathing function

❒ Eliminate allergies/asthma

❒ Improve immune system function

❒ Other:____

____

I authorize Dr.________________to examine (including x-rays) and provide treatment to my child. I recognize that I am fully responsible for payment of all services rendered on behalf of my child.

Signature of Parent:____