Pediatric Health History

Many types of stressors (physical, mental, chemical) and some seemingly unrelated factors can affect your child's health and interfere with their growing spine and nervous system. Please take a moment to answer the following questions to help us understand more about your child's health.

Spinal health is an exciting new concept for many people, so please remember to ask questions!

Who may we thank for referring you?____ Date___________________

Childs Name:____ Date of Birth_____________________

Mother's Name____________________________________ Email_______________________________________

Father's Name____________________________________ Email_______________________________________

Marital status of parents_______________ Are you legally entitled to consent to this child's care? YES_____ NO_____

Siblings Names and ages:____

Address_______________________________________ City__________________ State_____ Zip__________

Mother's Date of birth__________________ SSN__________________ Mobile phone________________________

Father's Date of birth___________________ SSN_________________ Mobile phone_________________________

Pediatrician__________________________ City&State___________________ Last visit_____________________

Purpose for last visit____

Birth height/length__________ Birth weight__________ Current height/length_________ Current weight__________

Has your child ever received Chiropractic care? Yes_____ No_____ Dr.&Last visit_____________________________

Insurance Company____

Please circle appropriately for the following information

Pregnancy and Birth history:

Child's gestational age at birth__________Wks   Was child born   cephalic*(head first)*   breech*(feet first)*

Type of Birth: Vaginal   Forceps   Suction cap or Vacuum   C-Section

Location: Home   Hospital   Birthing Center   Other

Any Evidence of birth trauma: Bruising   Respiratory depression   Stuck in birth canal   Odd shaped head   Cord around neck   Jaundice*(yellow)*   Cyanosis*(blue)*   Congenital Anomilies/defects

Any Problems during Pregnancy?____

Problems during delivery____

Length of Labor________________ How long pushing____________ Was Labor   Induced   Spontaneous

Medications or Epidural given during birth? *(Please list)*____

Was the infant alert and responsive within 12 hours after delivery?   YES   NO

If no please explain____

At what age did the child

Respond to sound__________   Follow an object__________   Hold head up__________

Sit alone__________   Teethe__________   Crawl__________   Walk__________

FEEDING/SLEEP:

Breast fed? Yes How long?________________________________ No
Bottle? If bottle what formula?_________________________________

Introduction to Cow's milk at what age?_________________Began Solid foods at what age?_________________

Any food or juice intolerance?____

Number of hours child sleeps per night_____________Quality of sleep Good Fair Poor

TRAUMA:

Has your child ever been treated in the Emergency room?__________Explain_____________________________

Has your child ever been hospitalized?__________Explain____

Has your child had any Surgeries?__________Explain____

Has your child ever suffered any of the following Spinal Traumas:

Fall from crib Fall from high chair Fall from changing table Fall from bed or couch

Fall off swing Fall off bike Fall down stairs Other________________

Does you child play sports?(list)____
Injuries?____

Has your child ever suffered from:

Headaches Dizziness Seizures Ear Infections/Pain Sinus trouble Colic

Asthma Irritability Walking Trouble Neck pain Back pain Growing pains

Digestive problems Reflux Poor appetite Constipation Diarrhea ADD/ADHD

Behavioral problems Frequent colds Bed wetting Other____________________________

REASON FOR CONSULTING OUR OFFICE:

Wellness Check-up Pain/Discomfort____
Injury____
If due to pain /discomfort/injury
Date of onset_________________Ever had problem before______________When_____________________
Medications taken for this problem?_______What_____________________When_____________________
Other Doctors seen for this problem?________Who_____________________When_____________________
Is problem getting: Better Worse Staying the Same

CONSENT TO CHIROPRACTIC CARE:

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _________________________________, being the parent or legal guardian of ___________________________
Hereby grant permission for my child to receive chiropractic care.

Signed____Date________________________________