Pediatric Health History

Today's Date:______________________

PATIENT INFORMATION:

Child's Name:___________________________________ Child's Nickname:_______________________________________

Present Health Challenge:____

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health: ___________

____

How do you feel your child's present health challenge effects his/her overall health and his/hers ability to experience an optimal quality of life? ____

____

Do you feel your child's environment is related to his/her present challenge? _______________________________________

Do you feel your child's present diet is related to his/her present health challenge? __________________________________

Sex: M / F Date of Birth:________________ Age:____________________ Child's SSN:___________________________

Child's Address and Phone (if different from yours): ____

Who may we thank for referring you?____

FAMILY INFORMATION:

Mother's Name:________________________________ Father's Name: _______________________________________

Address:_______________________________________ Address: _______________________________________

_______________________________________ _______________________________________

Home & Work Phone:___________________________ Home & Work Phone:___________________________________

Parents Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

List ages of other children in family:____

Predominant language used at home:____

PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name:________________________Birth Date:__________________SS#_________________________________

Insurance Company:_________________________________Phone No.:____

Employer:_________________________Group #:__________________Insured's ID:______________________________

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

PREGNANCY HISTORY

What was the term of your pregnancy? _____________ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

Yes/No

Falls _______________ Motor Vehicle Accidents _____________

Near-miss MVA _____________ High Blood Pressure ______________

Diabetes ______________ Anemia _______________

Morning Sickness _____________ Indigestion _______________

Seizures _______________ Swollen Ankles ________________

Thyroid Problems ______________ Heart Problems _________________

Back Pain _______________ Abnormal Bleeding ________________

Were you Hospitalized _____________ Any Other Illnesses (list) _______________

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

Yes/No

Tobacco ______________________ Alcohol ____________________

Non-Prescribed Drugs ______________ Prescription Medications _________________

Over-the-counter meds (list) ____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____________ hours

How long was the 2nd stage (the pushing phase) of the labor? ______________ hours

Yes/No

Hospital Birth ___________ Home Birth ___________

Midwife Assisted ___________ Vaginal Delivery __________

Planned C-Section __________ Emergency C-Section ___________

Was Birth Induced __________ Forceps Delivery ____________

Vacuum Extraction __________ Anesthesia Administered _______________

Fetal Distress ___________ Meconium Staining ______________

Head Presentation __________ Face Presentation _____________

Breech Presentation ___________

BABY'S CONDITION IMMEDIATELY AFTER BIRTH: (If Known)

Apgar Scores: At 1 minute __________/10 At 5 minutes ___________/10

Baby's Crying: Baby Cried Immediately After Birth ________ Cried Strongly ________

Weak Cry ________ Did Not Cry for ________minutes

Baby's Color: Pink All Over _______ Blue Face ________ Blue Hand / Feet ________

Baby's Activity: Arms and Legs Actively Moving ________ Floppy Baby ________

Intensive Care Was Required ________ Days in Neonatal Intensive Care Unit ________

Medication Given at Birth? ___________________________

Vaccines Administered ____

____

Birth Weight __________lbs / kgs Birth Length __________ ins / cms Baby Home on Day ___________________

INFANT HISTORY

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION:

If yes, please explain: ____

Is your child still being breast fed? If no, for how long was he / she breast fed? _________________________

If still breast feeding, how much cow's milk does the mother consume each day? __________________________

Is your child formula fed? Which formula or other milk source? ____________________________________

Is your child eating solid food? What foods does his / her diet contain? _________________________________

What is your child's favorite food? ____

Does your child have any feeding difficulties? ____

Does your child have any digestive disturbances?____

Does your child have any food allergies? ____

Does your child have any persistent or intermittent skin rashes? ____

Is your child receiving any vitamin supplements? ____

TRAUMA:

Has your child had any recent falls or trauma? (What and When)____

Has your child ever fallen down stairs or fallen from any height? (Where and When)________________________

Has your child ever been in a motor vehicle collision or near-miss? (What and When)_______________________

Has your child ever had a bone fracture or joint dislocation? (Where)____________________________________

Has your child had any other trauma or injuries? (Describe)____

Does your child ever bang his / her head repeatedly against a wall, bed or other object? ____________________

GROWTH AND DEVELOPMENT:

Can your child sit unsupported? At what age did your child start to sit-up? ________ months

Is your child crawling yet? At what age did your child start crawling? ________months

Is your child walking yet? At what age did your child start walking? ________months

Does your child often trip and fall? ____

Do you have any other concerns about your child's growth and development? ____________________________

HEALTH HISTORY:

Does your child ever complain of back or neck pain? ____

Does your child ever complain of pains in the arms or legs? ____

Does your child ever complain of headaches? ____

Has your child had any earaches? At what age did the first earache occur? _______________________________

How frequently does your child have earaches? ____

Do your child's earaches usually tend to occur in the same ear? Is it the right or left ear? ___________________

Which of the following has your child experienced? Indicate "C" (current) or "P" (past):

___ Skin conditions	___ Digestive complaints	____ Growing pains
__ Easy bruising	___ Difficulty sleeping	____ Allergies
__ Colic	___ Seizures	____ Pneumonia
__ Asthma	___ Constipation	____ Diarrhea
__ ADD/ADHD	___ Autism	____ Learning disabilities
__ Sinus troubles	___ Nausea/Vomiting	____ Upper Respiratory Infections
__ Bed wetting	___ Chicken pox	____ Mononucleosis
__ Impetigo	___ Measles	____ Bronchitis
__ Frequent infections	___ Strep throat	____ Thrush
__ Diaper rash	___ Urinary tract infections	____ Asthma

Has your child had any other illnesses? Please list each illness and its approximate date____________________

____

Is your child presently receiving any medications? ____

Has your child ever been to a hospital or emergency room for evaluation or treatment? ______________________

Has your child recently been vaccinated? ____

Do you have any other concerns about your child's health? ____

Any Other Important Info:

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✓We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
✓Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
✓I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
✓I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in medical status.

Signature ____ Date: _______________

Relationship to Patient _________________________