

PEDIATRIC HEALTH HISTORY (Ages 6-12)



Child's Name _____ DOB: _____ Age: ___ Male Female
Address _____ City _____ State _____ Zip _____
Height _____ Weight _____ Grade _____ # of Siblings _____ Ages _____
Mother _____ Cell# _____ Father _____ Cell# _____
Home Phone _____ Mothers / Fathers Email _____
Pediatrician/Family MD _____ Office Location: _____
Who is responsible for this account? Mother SS# _____ - _____ - _____ Father SS# _____ - _____ - _____
Whom may we thank for referring you? _____ Phone Book Website Sign Other _____

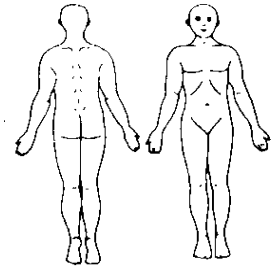
Welcome to our office. We are honored that you have chosen our office to serve your family. Please know that we will care for your child with the greatest respect and treat them as if they are our own. If your child has no complaints and is here for a wellness program, skip to wellness profile.

Current Complaint: *(circle, highlight or write where applicable)*

Primary Complaint _____

- a. Been a problem for: _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)
- b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other _____
- c. Condition came on: Sudden Gradual It is getting: Better Worse No Change
- d. Condition is: Constant Comes & Goes Feels worse in: AM Noon PM In Bed
- e. Does it radiate? Yes No Where: _____
- f. What makes it better? _____
- g. What makes it worse? _____
- h. Has your child seen anyone for this? Yes No Who? _____
- i. What were the results of the treatment? _____
- j. Any medications taken for this problem? _____
- k. How does this affect their life? *(circle/write)* poor school performance / irritability / interrupted sleep / fatigued restricted daily activities / hinders social activities / other _____

Mark areas below



Other Complaints *(briefly describe)* _____

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve for this child. *(Circle as many goals as you wish)*

- | | | |
|---------------------------|-------------------------------|---------------------------|
| More Energy | Better Sleep | Freedom from Pain |
| Easier Breathing | Improved Posture | Improved Nutrition & Diet |
| Improved Coordination | Eliminate Medications | Improved Overall Health |
| Better Sports Performance | Enhanced Emotional Well-Being | Better Concentration |
| Stronger Immune System | Other _____ | |

Continued on back...

Pregnancy & Birth History: (circle, highlight or write where applicable)

Experts say the birth process as we know it may cause extensive neurological trauma and damage.

- 1) Any ultrasounds during this pregnancy? Yes No # & Why? _____
- 2) Problems during pregnancy? Yes No What? (breech, diabetes) _____
- 3) Place of birth: Home Birthing Center Hospital Other _____
- 4) Birth Provider: Lay Midwife Nurse Midwife OB-Gyn Other _____
- 5) Was labor induced? Yes No Why? _____ Was anesthesia used? Yes No
- 6) How long was labor and delivery? _____ hours What week did you give birth? _____ wks
- 7) Type of Birth: Vaginal Vacuum Forceps C-Section (Planned) C-Section (Emergency)
- 8) Any Birth Trauma? (bruising/dislocations/Dr. pulling to get out) _____
- 9) Was there any: Jaundice (Yellow) Cyanosis (Blue) Congenital Anomalies/Defects
If yes, please explain _____

Infant History (0-24 months): (circle, highlight or write where applicable)

- 1) Did you breast feed your child? Yes No If yes, how long? _____ If no, any problems with formula? Yes No
- 2) Any developmental challenges? Yes No Explain: _____
- 3) Did you choose to vaccinate your child? Yes No If yes, were they on a Traditional or Modified Schedule?
Any adverse reactions from any vaccinations? Yes No _____
- 4) Any use of drugs or antibiotics? Yes No What & Why? _____

Health History: (circle, highlight or write where applicable any **past or present** health challenges)

- | | | | |
|---|------------------------|---------------------|--------------------|
| Asthma | Sinus Problems | Allergies | _____ |
| Frequent Colds | Ear Infections / Tubes | Headaches/Migraines | Seizures |
| Fainting | Dizziness | Behavioral Problems | ADD/ADHD |
| Neck Pain | Arm Pain | Back Pain | Leg Pain |
| Scoliosis | Poor Posture | Muscle Pain | Growing Pains |
| Colic | Constipation | Diarrhea | Digestive Disorder |
| Reflux | Stomach Aches | Bladder Problems | Bed Wetting |
| Poor Appetite | Anemia | SI Problems | _____ |
| Heart Condition | Night Terrors | Learning Disorders | _____ |
| Sleeping Trouble | Tantrums | ASD (type) | _____ |
| Falls over 3 ft (high chair, changing station, counter, playground) _____ | | | |

Overall Health History: (circle, highlight or write where applicable)

- 1) Current medications: _____
- 2) Vitamins/Herbs/Minerals/etc: _____
- 3) Does your child follow a special diet: Yes No _____
- 4) Does your child consume: (circle) Caffeine Processed Foods Artificial Sweeteners Soda
Fast Food Fresh Fruits Fresh Vegetables Sugar
- 5) Please list any sports your child plays: _____
- 6) How many hrs/day does your child spend: watching tv? _____ Playing computer/video games? _____
- 7) Please rate the following for your child: (P) Poor, (G) Good or (E) Excellent
Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Continued on next page...

Spinal Health: (circle, highlight or write where applicable)

- 1) Has your child ever had their vision checked by an optometrist before? Yes No
 - 2) Has your child ever had their teeth checked before? Yes No
 - 3) Has your child ever had their spine and nervous system checked by a doctor of chiropractic before? Yes No
- Who? _____ Date of last visit? _____ Reason for ending care? _____

4) Have they ever had spinal x-rays taken? Yes No When? _____ Were they standing? Yes No

5) Spinal misalignments can make you feel the need to twist, stretch or crack your neck or spine.

Does your child ever feel the need to twist, stretch or crack their neck or spine? Yes No

6) Poor posture leads to poor health and often indicates spinal problems. Please rate your child's posture?

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7) Stress can cause or accelerate spinal damage. Rate your child's stress level for the last 90 days.

Low - 1 2 3 4 5 6 7 8 9 10 - High

Injuries/Surgeries: (Date & Description)

Auto Accidents: _____

Recreational Accidents: _____

Fractures / Dislocations: _____

Surgeries: _____

Family History:

Does anyone in your family suffer with any of the following conditions? (Please circle or highlight Father &/or Mother)

F M Heart Disease F M Strokes F M Cancer (types): _____

F M High BP F M Thyroid F M Neurological - Parkinson's, ALS, MS, other _____

F M Diabetes F M Asthma F M Other _____

Would you like to receive our health and wellness newsletter (1-2 times per month via email)? Yes No

(Topics include: diet, exercise, stress management, women's and children's health, wellness topics, etc.)

Other facts concerning the health of any other family members which may or may not be relevant to your child's current state of health, but that you feel you would like the doctor to be aware of? _____

Consent to evaluate and treat a minor:

I, _____ being the parent or legal guardian of _____ have filled out the above information to be accurate to the best of my knowledge. After careful consideration I do hereby request and authorize a complete evaluation including imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care my child receives. Copies of any x-ray reports will be released upon written request, however the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years.

Parent or Legal Guardian's Signature

Date

Reviewed by: _____
Dr. Initials