PEDIATRIC HEALTH HISTORY (Ages 2-5)

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.

<u>Current Complaint:</u> *(circle, highlight or write where applicable)*

Primary Complaint____

a. Been a problem for: ______Day(s) ______Week(s) ______Month(s) ______Year(s)

b. Condition came on: Sudden Gradual It is getting: Better Worse No Change

c. Condition is: Constant Comes & Goes It is worse in: AM Noon PM In Bed

d. What makes it better? ____

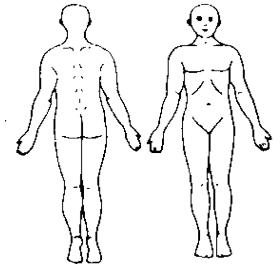
e. What makes it worse? ____

f. Has your child seen anyone for this? Yes No Who?_______________________________

g. What were the results of the treatment?____

h. Any medications taken for this problem?____

Mark areas below



i. How does this affect their life? *(circle/write)* poor school performance / irritability / interrupted sleep / fatigued hinders play time / other____

Other Complaints *(briefly describe)*____

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<u>Wellness Profile:</u> 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
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) At what age did your child: Hold head up______ Laugh______ Roll over (front to back)______

   Sit alone______ Crawl______ Stand______ Walk (unassisted)______
3) Any developmental challenges? Yes No Explain:______________________________
4) Did your child have at least 1 bowel movement per day? Yes No If no, how often______________
5) Did you choose to vaccinate your child? Yes No If yes, are they on a Traditional or Modified Schedule?

   Any adverse reactions from any vaccinations? Yes No______________________________
6) 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) How many hrs/day does your child spend in front of a tv, computer or video game?______________
6) 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 spine and nervous system checked by a doctor of chiropractic before? Yes No
   Who?______________________ Date of last visit?__________ Reason for ending care?____________________________
2) Have they ever had spinal x-rays taken? Yes No When?___________ Were they standing? Yes No
3) 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
4) 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.

____ ________________ Reviewed by:_________

Parent or Legal Guardian's Signature Date Dr. Initials