PEDIATRIC HEALTH HISTORY (Teenager)

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.

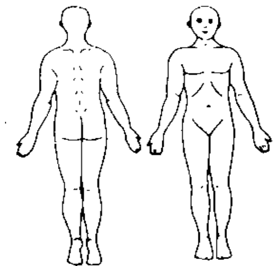
Current Complaint: *(circle, highlight or write where applicable)*

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______________

Mark areas below



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____

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_________________________________	

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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 problems during pregnancy? Yes No (breech, diabetes)______________________________________
2) Place of birth: Home Birthing Center Hospital Other______________________________
3) Birth Provider: Lay Midwife Nurse Midwife OB-Gyn Other______________________________
4) Was labor induced? Yes No Why?_________________________________ What week did you give birth?________
5) Type of Birth: Vaginal Vacuum Forceps C-Section (Planned) C-Section (Emergency)
6) Any Birth Trauma? (bruising/dislocations/Dr. pulling to get out)______________________________________
7) 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)______________	

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

Injuries/Surgeries: *(Date & Description)*

Auto Accidents:____

Recreational Accidents:____

Fractures / Dislocations:____

Surgeries:____

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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

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

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ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

Item	0	1	2	3	4
1) **Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2) **Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3) **Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4) **Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5) **Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6) **Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7) **Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8) **Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9) **Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10) **Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Patient Signature:____ Date:________________ Score:________