**PEDIATRIC HEALTH HISTORY**

Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_

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Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Parent’s Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any family member been a patient here? Yes \_\_\_ No \_\_\_ Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this patient had previous chiropractic care? Yes \_\_\_ No \_\_\_ Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT**

Please describe your child’s *major complaint*:

Date Started: \_\_\_\_\_\_\_\_\_\_\_\_ Had Before? Yes \_\_\_ No \_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Secondary Complaint*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Started: \_\_\_\_\_\_\_\_\_\_\_\_ Had Before? Yes \_\_\_ No \_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any that condition is interfering with: Sleep School Daily Routine Sports Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH HISTORY**

Delivery Method (circle all that apply) Vaginal C-Section Forceps Vacuum

 Epidural Induced Breech Back Birth

Location of Birth: \_\_ Hospital \_\_Birthing Center \_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractic care during the pregnancy? Yes\_\_\_ No \_\_\_ How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Complications during pregnancy? Yes\_\_\_ No \_\_\_ How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Drugs during? Yes\_\_\_ No \_\_\_ List: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette/Alcohol use during? Yes\_\_\_ No \_\_\_ Explain:\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known congenital anomalies or defects Yes\_\_\_ No \_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

Breast Fed? Yes\_\_\_ No\_\_\_ How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Formula Fed? Yes\_\_\_ No\_\_\_ How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Milk in Bottle? Yes\_\_\_ No\_\_\_ How Long?\_\_\_\_\_\_\_\_ Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food or other allergies? Yes\_\_\_ No\_\_\_ List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever taken antibiotics? Yes\_\_\_ No\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any prescription medication? Yes\_\_\_ No\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any vitamins or supplements? Yes\_\_\_ No\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had surgery? Yes\_\_\_ No\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency room visits Yes\_\_\_ No\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccinations up to date? Yes\_\_\_ No\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age Development: Rolled Over:\_\_\_\_\_\_\_\_ Sat Up:\_\_\_\_\_\_\_\_ Crawled:\_\_\_\_\_\_\_\_ Walked:\_\_\_\_\_\_\_\_ Talked: \_\_\_\_\_\_\_\_

Have you ever been concerned your child was not developing & achieving normal milestones? Yes:\_\_\_ No:\_\_\_

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

Mark with **N** if your child has the condition now. Mark with **P** **if child has suffered with condition in the past.**

**\_\_\_Fever \_\_\_Colic \_\_\_Croup \_\_\_Learning Disorders \_\_\_Poor Posture**

**\_\_\_Nervousness \_\_\_Constipation \_\_\_Bed-Wetting \_\_\_Weakness/Fatigue \_\_\_Allergies**

**\_\_\_Sinus Trouble \_\_\_Stomach Ache \_\_\_Loss of Hearing \_\_\_Ear Infections \_\_\_Arthritis**

**\_\_\_Numbness \_\_\_Irritability \_\_\_ Headache \_\_\_Neck Ache \_\_\_Backache**

**\_\_\_Sore Throat \_\_\_Eye Problem \_\_\_Cough \_\_\_Skin Disorders \_\_\_Scoliosis/Curvature**

**\_\_\_Wheezing \_\_\_Bronchitis \_\_\_Frequent colds \_\_\_Asthma \_\_\_Muscular Dystrophy**

**\_\_\_Cerebral Palsy \_\_\_Hip Foot Pain \_\_\_Arm/Hand pain \_\_\_Painful Joints \_\_\_Poor Circulation**

**\_\_\_Shoulder Pain \_\_\_Clumsiness \_\_\_Neurological \_\_\_One leg shorter \_\_\_Foot turned in/out**

**\_\_\_Autism \_\_\_Lack of Focus \_\_\_Overweight/Obesity \_\_\_Difficultly in school**

**HEALTH HABITS**

Please check any of the habits that your child has now:

\_\_\_Junk/Processed Food \_\_\_Aversion to Vegetables \_\_\_Has Breakfast Daily

\_\_\_Soda/High Sugar Drinks \_\_\_Diet Drinks \_\_\_Adequate Water Intake

\_\_\_High Activity Leve/Exercise \_\_\_Low Activity Level/Sedentary \_\_\_High Impact Sports

\_\_\_Excessive Computer Use \_\_\_Excessive TV/Video Games \_\_\_Trouble Sleeping

Favorite Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT TRAUMA HISTORY**

Any falls during the first year (Example: From a bed, changing table, down the stairs, etc.) Yes: \_\_\_ No: \_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been involved in any high-impact sports or contact-type sports (i.e. football, soccer, gymnastics, hockey, basketball, martial arts, etc.)? Yes: \_\_\_ No: \_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been involved in an automobile accident? Yes: \_\_\_ No: \_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any residual health complications related to the accident? Yes: \_\_\_ No: \_\_\_

Has the child had any additional falls or traumas or health issues not yet listed? Yes: \_\_\_ No: \_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Please mark family history of the conditions using the following key: M=mother, F=father, S=siblings

\_\_\_\_\_\_\_\_\_\_\_\_ Allergies \_\_\_\_\_\_\_\_\_\_\_\_Asthma \_\_\_\_\_\_\_\_\_\_\_\_Cancer

\_\_\_\_\_\_\_\_\_\_\_\_ Heart Condition \_\_\_\_\_\_\_\_\_\_\_\_High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_Mental Illness

\_\_\_\_\_\_\_\_\_\_\_\_ Scoliosis \_\_\_\_\_\_\_\_\_\_\_\_Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_Liver Disease

\_\_\_\_\_\_\_\_\_\_\_\_ Depression \_\_\_\_\_\_\_\_\_\_\_\_Stroke \_\_\_\_\_\_\_\_\_\_\_\_Overweight/Obesity

\_\_\_\_\_\_\_\_\_\_\_\_ Skin Conditions \_\_\_\_\_\_\_\_\_\_\_\_Diabetes \_\_\_\_\_\_\_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I agree to be financially responsible for any charges & I also authorize treatment of a minor*

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_