

Pediatric Health History Form

Name _____ Date _____

Age _____ Birth Date _____ Male / Female

Mother's Name _____ Father's Name _____

Address: _____ Address: _____

Phone: home/cell/work _____ Phone: home/cell/work _____

Email: _____ Email: _____

Does the patient regularly see a pediatrician? _____ Pediatrician's Name: _____

Reason For Consulting Office: _____

Whom may we thank for referring you? _____

Present Health Challenge

If your child does not currently have a health challenge please indicate here with an "X" _____

If you child DOES currently have a health challenge please provide a brief history of the issue including the effect it is having on the child? _____

If your child is experiencing pain, is it (please circle): Sharp Dull Comes and Goes Travels Constant

Since the issue started is it: About the Same Getting Better Getting Worse

What makes it worse?: _____

What makes it better?: _____

Is it interfering with?: School Sleep Walking Sitting Hobbies Other _____

Other Health Care Professionals Seen for this problem:

Chiropractor: _____ Medical Doctor: _____ Other: _____

Please List Medications Child is taking or Surgeries the Child Has Had:

Pregnancy:

Were there any complications to the pregnancy? _____

Was mom on any medications, prescriptions or over the counter? _____

If yes please explain _____

Did mom or dad smoke during the pregnancy? _____ If so, who? _____

Drink alcohol? Yes No How much? _____

Any illnesses during the pregnancy? Yes No If yes, describe: _____

Any supplements taken during pregnancy? Yes No If yes, describe: _____

Any ultrasounds? Yes No How many: _____ Reasons for being done: _____

Was the baby ever in breech presentation? Yes No

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? Yes No If yes, please explain

Any pets at home? Yes No _____

Birth and Delivery

Was your child's birth: (Check all that apply) at home in a birthing center hospital medical midwife other

Was the delivery? Vaginal C-section Episiotomy Were there any devices used? No Forceps Vacuum

How long was the labor? _____ How long was the delivery? _____

Were there any complications? Yes No If Yes, please explain _____

Was oxytocin/pitocin used? Yes No

What was the child's gestational age at birth? _____ weeks.

Birth weight _____ lbs _____ oz Birth length _____ inches

Was child born: cephalic (head first) breech (feet first)

Were medications or epidurals given to the mother during birth? Yes No

Is there anything else we need to know about the birth Yes No

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain _____

At what age did the child: Respond to sound _____ Hold up head _____ Sit alone _____ Crawl _____ Follow an object _____

Vocalize _____ Teethe Walk _____

Does your child sleep: front back side

Do you consider the child's sleeping pattern normal? Yes. No How many hours per day? _____

Infancy

Was the child vaccinated? _____

Were there any prolonged use of medications, antibiotics, or an inhaler? Yes No If yes which? _____

For what reason? _____

Did the infant suffer any traumas such as serious falls or accidents? _____

Was this child: breast-fed formula-fed For how long? _____

Any difficulties with lactation? Yes No _____

Any problems with bonding? Yes No _____

Introduction of milk at what age: Cow's _____ Almond _____ Rice _____ Soy _____ Other _____

Began solid foods at what age: _____ Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is the diet organic? Yes No

Do you use 'green products' in your home for cleaning? Yes No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? Never On weekends A few times per week Daily Nearly each meal On special occasions

Are you aware of the impact of nutrition on children's behavior? Yes No

Would you like information on nutrition for your child? Yes No

I acknowledge that the statements in this form are accurate to the best of my recollection and I request and give consent to this office to examine and administer chiropractic care for my child.

Parent's Signature _____ Date _____