

PEDIATRIC HEALTH INFORMATION

Welcome to our office! Please give us the following details about your child, their life events, and their health. If you do not understand any of these questions, please feel free to ask.

Personal Information

Patient's Name: _____
Parents / Guardians: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Date of Birth: _____ Age: _____
Gender: Male Female Siblings: _____ Birth Weight: _____ Length: _____
In Case Of Emergency Notify: _____ Phone: _____
Family Physician / Pediatrician: _____
Obstetrician/Midwife: _____
Your E-Mail: _____
Who Should We Thank For Telling You About Our Office? _____

Current Health Concern

Primary Reason for Today's Visit: _____
Check the Severity of the Complaint: (Mild) (Severe)
When Did This Begin? _____ Experienced Previously? Yes Never
Is This Condition: Illness Related Auto Accident Fall or Injury Other: _____
Other Doctors Seen For This Problem: _____
Other Doctor's Opinions or Diagnosis: _____
Drugs or Medications Now Taking: Antibiotics Tranquilizers
 ADD/ADHD Meds Pain Killers
 Other: _____

Past Health History

3rd Trimester Presentation: Vertex _____ Breech _____ Transverse _____ Face/Brow _____
Type of Birth: Vaginal Forceps Vacuum extraction Caesarian section
Complications during pregnancy: yes no describe: _____
Complications during delivery: yes no describe: _____
Apgar Score: _____ Was there presence of Jaundice _____ Cyanosis (blue) _____
Congenital Anomalies/Defects? _____ If Yes, Explain _____
Previous fractures or broken bones: yes no describe: _____
Previous falls or accidents: yes no describe: _____
Previous hospitalization: yes no describe: _____
Previous chiropractic care: yes no describe: _____
Similar problem in family: yes no describe: _____
Began to walk alone at age: _____ Immunization History: _____
Feeding history: breast fed formula fed until age: _____
Introduced to solid foods at age: _____

PEDIATRIC HEALTH HISTORY

Child's Health Issues:

- | | | | |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Other Infections | <input type="checkbox"/> Colic | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Illnesses |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Colic | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Over Weight | <input type="checkbox"/> Tantrums | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Under Weight | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Other _____ | |

Check Any of the Following That May Apply

Other Complaints

Muscles-Skeleton

- Low Back Pain
- Middle Back
- Neck
- Hips / Legs
- Joint Pain
- Shoulders/Arms

Circulation-Breathing

- Chest Pain
- Lungs/Breathing
- Blood Pressure
- Heart Rate
- Poor Circulation
- Coughing or Wheezing

Eye-Ear-Nose-Throat

- Eyes / Vision
- Dental / TMJ
- Throat / Voice
- Ears / Hearing
- Sinus Pain / Drainage

Check Any Complaints Your Child May Have Had In the Last Six Months

Nerve System

- Headaches
- Nervousness
- Numbness
- Weak Muscles
- Dizziness
- Forgetfulness
- Depression
- Fainting
- Change In Stools

Digestion-Elimination

- Poor Appetite
- Excessive Thirst
- Nausea
- Diarrhea
- Constipation
- Hemorrhoids
- Weight Loss / Gain
- Heartburn

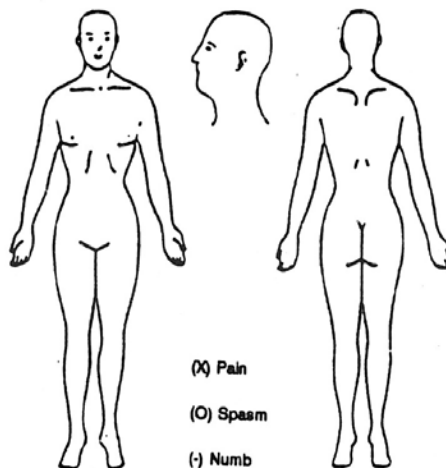
Urinary-Genitals

- Pain With Urination
- Infrequent Urination
- Frequent Urination
- Weak Stream
- Bladder Control
- Genital Pain or Symptoms
- Stress Reactions
- Cold Hands / Feet

Female Only

- Menstrual Problems
- Breast Lumps/Pain
- Back Pain w/ Period
- Birth Control Pills

Please Mark Areas Of Concern



I understand that the care of my child involves the making of judgements that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge.

I hereby request and authorize the examining and the subsequent rendering of chiropractic care to my child.

Parent or Gaurdians Signature: _____