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, please explain _____

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

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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**_____