Pediatric Health History Form

Child's Name: ______________________________ Date:__________________

Parent Names: ___________________________ Sibling's Names & Ages:____________________________

Child's Age: ____________ Birth date: __________________ (dd/mm/yyyy) Sex: □ M □ F

Address:____

Home Phone:________________________________ Other Number:__________________________________

Family doctor's name: _____________________________ Address:_________________________________

Who may we thank for referring you?____

Has your child ever received chiropractic care? □ Yes □ No

If yes, who is your child's previous Doctor of Chiropractic?:____

The date of last visit:____

The reason for the last visit:____

Other professionals seen for this condition: ____

Results with that treatment? ____

Please tick the purpose for your child's visit:

□ crisis management □ prevention □ wellness

□ maximizing normal growth and development □ other:____

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Present Health Concerns

Major____

Minor____

When did this problem begin?____

Is this problem: ☐ occasional ☐ frequent ☐ constant ☐ intermittent

Does problem radiate? ☐ *Yes* ☐ *No* If Yes, where? ____

What makes this worse?____

What makes this better?____

Is the problem worse during a certain time of the day? ☐ *Yes* ☐ *No*

If Yes, when?____

Does this interfere with the child's sleep? ☐ *Yes* ☐ *No* Eating? ☐ *Yes* ☐ *No* Daily routine? ☐ *Yes* ☐ *No*

Is this becoming worse? ☐ *Yes* ☐ *No*

Often seemingly unrelated symptoms can manifest as other health concerns..
Please tick if your child has had any of the following

☐ headaches	☐ chest pressure	☐ weight loss
☐ dizziness	☐ breast pain	☐ weight gain
☐ irritability	☐ frequent colds	☐ dental problems
☐ fatigue	☐ sinus congestion	☐ fevers
☐ depression	☐ sore throats	☐ heart palpitations
☐ loss of balance	☐ ear pain/infections	☐ numbness in feet
☐ loss of concentration	☐ asthma	☐ numbness in hand(s)
☐ fainting	☐ cold sweats	☐ weakness
☐ ears buzzing	☐ bronchitis	☐ heartburn
☐ poor coordination	☐ pneumonia	☐ muscle cramps
☐ vision changes	☐ difficulty breathing	☐ upper back pain
☐ loss of memory	☐ shortness of breath	☐ neck pain
☐ loss of smell	☐ allergies	☐ low back pain
☐ loss of taste	☐ constipation	☐ radiating pain
☐ light sensitivity	☐ diarrhea	☐ sleeping problems
☐ face flushed	☐ urinary problems	☐ numbness in leg(s)
☐ reduced mobility	☐ bloating/gas	☐ stiffness

☐ Other: ____

Birth History

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

Birth weight _______lbs ______oz Birth length _______ inches

Was your child's birth: ☐ at home ☐ in a birthing center ☐ hospital ☐ other

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Was the birth considered: ☐ medical ☐ midwife Duration of birth: ___________ hours
Was child born: ☐ cephalic (head first) ☐ breech (feet first)
Were there any complications? ☐ *Yes* ☐ *No* If Yes, please explain _______________________________
Assistances used during delivery: ☐ Forceps ☐ Vacuum extraction ☐ C-section ☐ Episiotomy
Was labour: ☐ spontaneous ☐ induced
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 _____	Follow an object _____
Hold up head _____	Vocalize _____
Sit alone _____	Teethe _____
Crawl _____	Walk _____

Does your child sleep: ☐ front ☐ back ☐side
Do you consider the child's sleeping pattern normal? ☐ *Yes* ☐ *No* How many hours per day? __________
If no, please explain ____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:
Mothers family ____
Fathers family ____
Siblings ____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.
Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ☐ *Yes* ☐ *No*
If yes, please explain ____

Any evidence of birth trauma to the infant?

☐ *bruising*	☐ *odd shaped head*
☐ *stuck in birth canal*	☐ *fast or excessively long birth*
☐ *respiratory depression*	☐ *cord around neck*

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Any falls from couches, beds, change tables, etc? ☐ *Yes* ☐ *No*
If yes, please explain ____

Any traumas resulting in bruises, cuts, stitches or fractures? ☐ *Yes* ☐ *No*
If yes, please explain ____

Any hospitalizations or surgeries? ☐ *Yes* ☐ *No*
If yes, please explain ____
Any sports played? ____

Is a school backpack used? ☐ *Yes* ☐ *No* Is it ☐ heavy or ☐ light?

Chemical Stressors

Was this child breast-fed? ☐ *Yes* ☐ *No* If yes, how long: ______________________________
Formula introduced at what age: __________ Which formula? ______________________________
Introduction of cow's milk at what age: ______________ Began solid foods at what age: ______________
Types of solid foods:____

Food/Juice intolerance? ☐ *Yes* ☐ *No* Type: ______________________________________
Is your child on or have taken any medications? ______________________________________
During the mother's pregnancy:

Did the mother smoke? ☐ *Yes* ☐ *No* How much? ______________________________________

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 drugs taken during pregnancy? ☐ *Yes* ☐ *No* ______________________________________

Any ultrasounds? ☐ *Yes* ☐ *No* How many:___________ Reasons for being done:______________
____

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

Any pets at home? ☐ *Yes* ☐ *No* ____

Any smokers in the home? ☐ *Yes* ☐ *No*

Any antibiotics given? ☐ *Yes* ☐ *No* If yes, reason: ______________________________________

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*

Psychosocial Stressors

Any difficulties with lactation? ☐ *Yes* ☐ *No* ______________________________________

Any problems with bonding? ☐ *Yes* ☐ *No* ______________________________________

Any behavioral problems? ☐ *Yes* ☐ *No* ______________________________________

Any inattention? ☐ *Yes* ☐ *No* ______________________________________

Any hyperactivity or restlessness? ☐ *Yes* ☐ *No* ______________________________________

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Any compulsiveness? ☐ *Yes* ☐ *No* ____

Any difficulties at daycare or school? ☐ *Yes* ☐ *No* ____

Any challenges with learning deficiencies? ☐ *Yes* ☐ *No* _______________________________________

Any night terrors, sleep walking, difficulty sleeping? ☐ *Yes* ☐ *No* _______________________________

Any prolonged temper tantrums or separation anxiety? ☐ *Yes* ☐ *No* ______________________________

Is the child in day care ☐ *Yes* ☐ *No* ____

Age of child when began daycare? ____

Is there a nanny or regular sitter during the day if both parents work ☐ *Yes* ☐ *No* ______________

Is the child home schooled? ☐ *Yes* ☐ *No* ________________by Whom? ____________________________

Average number of hours of television per week? ________

Average number of hours of video games per week? ________

Does your child have a cell phone? ☐ *Yes* ☐ *No* How often do they text or use the phone? ______________

Do you feel that your child's social and emotional development is normal for their age? ☐ *Yes* ☐ *No*

____

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.