

# Pediatric Health History (Ages 1-3)

*Thank you for choosing chiropractic care for your child. Please complete this form in ink and print clearly. If you have any questions, do not hesitate to ask for assistance.*

**Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Person responsible for child's account:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Who may we thank for referring you to our office?** \_\_\_\_\_

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## Insurance Information

**Name of insured:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Insured Birth Date:** \_\_\_\_\_ **Social Security#** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Policy #** \_\_\_\_\_ **Group#** \_\_\_\_\_

**Insurance Co. Address:** \_\_\_\_\_

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**Medical Pediatrician:** \_\_\_\_\_ **Date of Last Visit:** \_\_\_\_\_

**Address of Pediatrician:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Dr.'s Assistant:** \_\_\_\_\_

**Other Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Other Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

May we share your child's health history and exam with these doctors?  Yes  No

## Family Medical History

Please check if any biological relatives to your child had any of the following illnesses and indicate which relative by noting: M (Mother), F (Father), S (Sibling), PGM (Paternal Grandmother), PGF (Paternal Grandfather), MGM (Maternal Grandmother), or MGF (Maternal Grandfather)

- |                                   |                                |
|-----------------------------------|--------------------------------|
| _____ Asthma or Allergies         | _____ Neck or Back Pain        |
| _____ Cancer                      | _____ Headaches                |
| _____ Diabetes or Low Blood Sugar | _____ Arthritis/Joint Pain     |
| _____ Heart Trouble               | _____ Scoliosis                |
| _____ High Blood Pressure/Stroke  | _____ Nervous System Disorders |
| _____ Kidney Disease              | _____ Liver Disease            |

Other: \_\_\_\_\_

**Have any of your other children been diagnosed with any health problems?**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Health status: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Health status: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Health status: \_\_\_\_\_

**Which areas were affected by the mother during pregnancy:**

- Headaches       Neck Pain       Midback Pain       Lower Back Pain
- Numbness/Tingling in Arm/Hand       Numbness/Tingling in Leg/Foot       Muscle Weakness
- Other: \_\_\_\_\_

**Labor & Delivery**

Duration of pregnancy: \_\_\_\_\_ Premature Delivery (how long): \_\_\_\_\_

Duration of labor: \_\_\_\_\_  Vaginal       Induced       Cesarean

Delivery Complications:  Epidural       Forceps       Suction cup       Other: \_\_\_\_\_

Incubation Duration: \_\_\_\_\_

**Please check any problems your child has recently experienced:**

- Difficulty Nursing       Trouble Sleeping       Excessive Crying       Irregular Breathing       Coughing

Other Issues: \_\_\_\_\_

Medications: \_\_\_\_\_

Surgeries: \_\_\_\_\_

**Does your child experience any of the following conditions:**

- Right Ear Infection    Currently    Last episode \_\_\_\_\_  
 Left Ear Infection    Currently    Last episode \_\_\_\_\_

What treatment(s) has your child received?    Antibiotics    Ear Tubes    Other: \_\_\_\_\_

Which treatment resolved the situation? \_\_\_\_\_

Which vaccines has your child received? \_\_\_\_\_

Has your child had any adverse drug or vaccine reactions?    Yes    No

Which drugs/vaccines caused the reaction(s): \_\_\_\_\_

Has your child ever been rendered unconscious or had a convulsion or seizure? \_\_\_\_\_

Problems with the eyes or vision?    Currently    Last episode \_\_\_\_\_

Problems with hearing?    Currently    Last episode \_\_\_\_\_

Problems with speech?    Currently    Last episode \_\_\_\_\_

Problems with breathing or asthma?    Currently    Last episode \_\_\_\_\_

Allergies (ie: hay fever, dust, hives)    Currently    Last episode \_\_\_\_\_

Skin, hair, nail or tooth problems?    Currently    Last episode \_\_\_\_\_

Stomach issues (pain, vomiting, etc)    Currently    Last episode \_\_\_\_\_

Bowel issues (diarrhea, constipation)    Currently    Last episode \_\_\_\_\_

Does your child's stool look or smell abnormal?    Currently    Last episode \_\_\_\_\_

Unusual urination frequency/smell/appearance?    Currently    Last episode \_\_\_\_\_

Does your child move normally and play without difficulty?    Yes    No   \_\_\_\_\_

Does your child limp or have an unusual gait pattern?    Yes    No   \_\_\_\_\_

Does your child complain of any head, neck or back pain?    Currently    Last episode \_\_\_\_\_

Does your child complain of pains in their arms and/or hands?    Currently    Last episode \_\_\_\_\_

Does your child complain of pains in their legs and/or feet?    Currently    Last episode \_\_\_\_\_

What aspects of your child's health or behavior would you like improved? \_\_\_\_\_

\_\_\_\_\_

## Nutrition

How many times each day do you breast feed your child? \_\_\_\_\_

Do you use commercial feeding formula?  No  Yes, but also with breast milk  Exclusively

Do you feed your child:  Home-made vegetables  Home-made fruits  Home-made cereals

Commercial jar baby food  Box cereals  Other: \_\_\_\_\_

Which beverages does your child mostly drink?  Water  Cow Milk  Soy Milk  Fruit Juice

Does your child have any food allergies?  Yes  No Please list: \_\_\_\_\_

Has your child been tested for food allergies?  Yes  No When? \_\_\_\_\_

Is your child currently on a restricted food diet?  Yes  No How Long? \_\_\_\_\_

## Chiropractic Care

Have you ever been to a chiropractor?  Yes  No When? \_\_\_\_\_

Has your child ever been to a chiropractor?  Yes  No When? \_\_\_\_\_

What do you want to achieve with chiropractic care for your child (and your family)?

Increase overall health and wellness

Decrease and eliminate symptoms

Prevent future symptoms from re-occurring

Improve heart/circulation functioning

Improve lung/breathing function

Eliminate allergies/asthma

Improve immune system function

Other: \_\_\_\_\_

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I authorize Dr. \_\_\_\_\_ to examine (including x-rays) and provide treatment to my child. I recognize that I am fully responsible for payment of all services rendered on behalf of my child.

**Signature of Parent:** \_\_\_\_\_