

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: _____ **City:** _____ **Zip:** _____

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? _____

Insurance Information

Name of insured: _____ **Relation:** _____

Insured Birth Date: _____ **Social Security#** _____

Insurance Company: _____ **Phone:** _____

Insurance Policy # _____ **Group#** _____

Insurance Co. Address: _____

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: _____ Health Concerns: _____

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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? _____ Not Applicable

Do you use commercial feeding formula? No Yes, and breast milk Exclusively NA

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: _____

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: _____