



# CONFIDENTIAL PEDIATRIC PATIENT HISTORY



Name \_\_\_\_\_ Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Parents' Names \_\_\_\_\_

Mother Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Father Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

Email \_\_\_\_\_

Previous Chiropractic Care?      Yes      No      Approximate Last Visit Date: \_\_\_\_\_

Insurance Company \_\_\_\_\_

## REASON FOR VISIT

The reason for this visit is the result of (please circle): Auto Injury    Fall    Sports    Chronic    Wellness Spinal Check    Other

Please describe your major complaint and how it happened: \_\_\_\_\_

\_\_\_\_\_

Date Started \_\_\_\_/\_\_\_\_/\_\_\_\_ Had before?    Yes    No    Please Describe: \_\_\_\_\_

\_\_\_\_\_

Is the condition interfering with (check all that apply): Sleep    School    Daily Routine    Sports

## BIRTH HISTORY

Delivery Method (check all that apply):    \_\_\_ Vaginal    \_\_\_ C-section    \_\_\_ Forceps    \_\_\_ Vacuum

   \_\_\_ Breech    \_\_\_ Back birth    \_\_\_ Epidural

Location of Birth:                                    \_\_\_ Hospital    \_\_\_ Home    \_\_\_ Birthing center

Chiropractic care during the pregnancy?      Yes      No

Any complications during pregnancy or delivery? Yes    No    If yes, explain \_\_\_\_\_

Ultrasounds during pregnancy?                    Yes      No    List #: \_\_\_\_\_

Medications/drugs/caffeine during pregnancy? Yes    No    If yes, list: \_\_\_\_\_

Cigarette/alcohol use during pregnancy?      Yes      No    If yes, which? \_\_\_\_\_

Any known congenital anomalies or defects? Yes    No    If yes, explain \_\_\_\_\_

## HEALTH HISTORY

Breast Fed?    Yes      No    How long? \_\_\_\_\_

Formula Fed?                                        Yes      No    How long? \_\_\_\_\_

Food or other allergies?                        Yes      No    List: \_\_\_\_\_

Has your child ever taken antibiotics?      Yes      No    Explain: \_\_\_\_\_

Any other prescription medication?        Yes      No    Explain: \_\_\_\_\_

Has your child ever had surgery?            Yes      No    Explain: \_\_\_\_\_

Ever visited the emergency room?          Yes      No    Explain: \_\_\_\_\_

## REVIEW OF SYSTEMS

Mark with “**N**” if your child has the condition now; “**P**” if he/she has suffered from it in the past.

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Fever          | <input type="checkbox"/> Colic                | <input type="checkbox"/> Croup                | <input type="checkbox"/> Learning Disorders | <input type="checkbox"/> Poor Posture           |
| <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Bed-wetting          | <input type="checkbox"/> Weakness/fatigue   | <input type="checkbox"/> Allergies              |
| <input type="checkbox"/> Sinus Trouble  | <input type="checkbox"/> Stomachache          | <input type="checkbox"/> Loss of Hearing      | <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Numbness       | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Headache             | <input type="checkbox"/> Neck ache          | <input type="checkbox"/> Backache               |
| <input type="checkbox"/> Sore Throat    | <input type="checkbox"/> Eye problems         | <input type="checkbox"/> Cough                | <input type="checkbox"/> Skin Disorders     | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Scoliosis/curvature  | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Frequent Colds     | <input type="checkbox"/> Muscular Dystrophy     |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Poor concentration   | <input type="checkbox"/> Arm/hand pain        | <input type="checkbox"/> Painful joints     | <input type="checkbox"/> Hip/leg/foot pain      |
| <input type="checkbox"/> Shoulder pain  | <input type="checkbox"/> Clumsiness           | <input type="checkbox"/> A foot turned in/out | <input type="checkbox"/> One leg shorter    | <input type="checkbox"/> Neurological condition |
| <input type="checkbox"/> Lack of focus  | <input type="checkbox"/> Difficulty in school | <input type="checkbox"/> Overweight/Obesity   |   |   |

## HEALTH HABITS

Please check any of the habits that your child has:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Junk Food  | <input type="checkbox"/> Healthy Foods                | <input type="checkbox"/> Breakfast Daily       |
| <input type="checkbox"/> Soda/High Sugar Drinks   | <input type="checkbox"/> Diet Drinks                  | <input type="checkbox"/> Adequate Water Intake |
| <input type="checkbox"/> High Activity Level/Exercise                                   | <input type="checkbox"/> Low Activity Level/Sedentary | <input type="checkbox"/> High Impact Sports    |
| <input type="checkbox"/> Excessive Television/Computer use (Average hours per day ____) |   |  |
| <input type="checkbox"/> Excessive Handheld Videogame use (Average hours per day ____)  |   |  |

## PATIENT TRAUMA HISTORY

Approximately 50% of children fall head first from a high place during the first year of life (i.e. bed, changing table, down stairs, etc.) Was this the case with your child? Yes No If yes, explain: \_\_\_\_\_

Has your child ever been involved in any high-impact sports or contact-type sports (i.e. football, soccer, gymnastics, hockey, basketball, martial arts, etc.)? Yes No If yes, list: \_\_\_\_\_

Has your child ever been involved in an automobile accident? Yes No Date: \_\_\_\_\_ Explain: \_\_\_\_\_

Any residual health complications related to accident? \_\_\_\_\_

Any additional falls, traumas, or health related issues not yet listed? \_\_\_\_\_

## FAMILY HISTORY

Please mark family history of the below conditions using the following key:

**M**=mother      **F**=father      **S**=sibling      **PG**=paternal grandparent      **MG**=maternal grandparent

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Heart Conditions   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Scoliosis   |
| <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Depression     | <input type="checkbox"/> Stroke      |
| <input type="checkbox"/> Overweight/Obesity | <input type="checkbox"/> Skin Conditions     | <input type="checkbox"/> Lack of Focus  | <input type="checkbox"/> Other _____ |

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT TRAUMA HISTORY

**Most patients have had dozens of IMPACTS throughout their life that could cause SUBLUXATIONS (spinal misalignments). The doctor wants to discover at least 5 of yours.**

**List below any auto accidents, work, home, sports injuries, or falls.**

1. **When was your most recent/most significant auto accident?** Date? \_\_\_\_\_  
Briefly Describe: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

2. **Any previous auto accidents?** Date? \_\_\_\_\_  
Briefly Describe: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

3. **When was your most recent/most significant work injury?** Date? \_\_\_\_\_  
Briefly Describe: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

4. **Any previous work injuries?** Date? \_\_\_\_\_  
Briefly Describe: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

5. **When was your most recent sports/recreational injury?** Date? \_\_\_\_\_  
Briefly Describe: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

6. **Any previous sports/recreational injuries?** Date? \_\_\_\_\_  
Briefly Describe: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

**Please list any other important traumas (i.e. childhood traumas, illnesses, fractures, sprains, surgeries) not mentioned:** Date? \_\_\_\_\_

Briefly Describe Trauma: \_\_\_\_\_

Any treatment received?    Y    N    Describe: \_\_\_\_\_    Chiropractic care?    Y    N

# QUALITY OF LIFE RATINGS

Subluxations affect our quality of life in many ways. Please circle the number that best represents how you rate your quality of life and lifestyle habits.

**SLEEP DISTURBANCE** (0 = none, 10 = worst imaginable)

0    1    2    3    4    5    6    7    8    9    10

**STRESS** (0 = none, 10 = worst imaginable)

0    1    2    3    4    5    6    7    8    9    10

**FATIGUE** (0 = none, 10 = worst imaginable)

0    1    2    3    4    5    6    7    8    9    10

**MOVEMENT PROBLEMS** (eg. Getting out of a chair, getting out of bed, walking with ease)

0    1    2    3    4    5    6    7    8    9    10

**DIET** (0 = organic, fruits & veggies, water; 10 = all processed, junk food or fast food, soda)

0    1    2    3    4    5    6    7    8    9    10

**FOCUS/CONCENTRATION/MEMORY ISSUES** (0 = no problems, 10 = severe problems)

0    1    2    3    4    5    6    7    8    9    10

Lastly, please tell us on average how many days per week you **EXERCISE:**

0    1    2    3    4    5    6    7