

COMPREHENSIVE PEDIATRIC HISTORY

Child's Name: _____ Age: _____ Grade Level (if applicable): _____

Mom's Name: _____ Dad's Name: _____

Primary Reason For Today's Visit: _____

When did the problem begin: _____ How: _____

Since the condition began, is it: Getting Worse Getting Better Staying the Same

Have you sought any other treatment?: _____

Has there been an episode like this in the past?: _____

What brings your child relief: _____

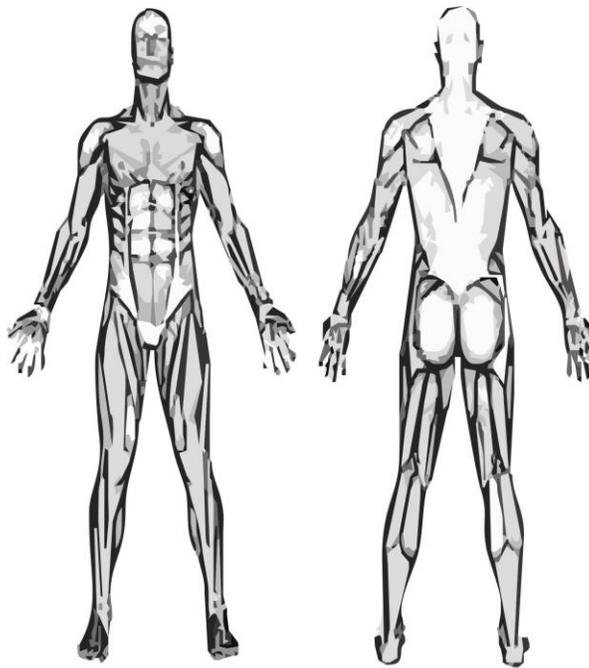
What makes your child worse: _____

Has this affected your child's:

Attendance at school Home Life Sports/Hobbies Sleep / Wake up well rested

Other: _____

IF YOUR CHILD IS EXPERIENCING PAIN, PLEASE CIRCLE & DESCRIBE THE AFFECTED AREA(S):



Please give a number to grade your pain: _____
(1 = no pain → 10 = Unbearable Pain)

Please circle all words that describe the pain:

Dull Ache Stiff Spasm Sharp Shooting
Tingling Weakness Other: _____

Please circle how often the pain is present:

Constant (100 – 81%) Frequent (80 – 51%)
Occasional (50 – 26%) Intermittent (25 – 0%)

Circle any/all of the listed that BRINGS RELIEF:

Nothing Standing Sitting Heat Cold Stretching
Lying Down Moving Around Other: _____

Circle any/all of the listed that MAKES YOUR WORSE:

Nothing Standing Sitting Heat Cold Stretching
Lying Down Moving Around Other: _____

Does your child have any other painful/chronic conditions that affect him/her daily or periodically?:

Parent/Guardian Initials: _____

Name: _____

Date: _____

PEDIATRIC HEALTH HISTORY

Please answer the following questions to the best of your ability.

During pregnancy, did Mom:

Experience any fertility issues while trying to conceive? No Yes

If yes, please describe: _____

Have ultrasound exams?: No Yes If yes, how many: _____

Take any medications?: No Yes If yes, please describe: _____

Consume alcohol?: No Yes If yes, please describe: _____

Smoke tobacco / other?: No Yes If yes, please describe: _____

Ingest "street drugs"?: No Yes If yes, please describe: _____

Were there any complications or injuries during pregnancy?: No Yes

If yes, please describe: _____

Labor & Delivery:

Did Mom carry to full term?: Yes No If no, how many weeks gestation: _____

Did Mom deliver at the hospital?: Yes No If no, where was Baby delivered?: _____

What type of care provider did you use?: OB/GYN Midwife None

Was baby delivered: Vaginally Cesarean With Forceps With Vacuum Extraction

Was the birth induced?: No Yes If yes, at what point: _____ Why: _____

Was the birth difficult?: No Yes If yes, please describe: _____

Was pain medication used?: No Yes If yes, what type: _____

Infancy:

If your child was a boy, is he circumcised?: No Yes If yes, any issues: _____

Was Baby breastfed?: No Yes If yes, for how long: _____

Infancy thru Adolescence: Did your child ever experience / is your child currently experiencing:

Frequent Crying Spells / Colic

Bed Wetting

Diagnosis of Scoliosis

Noticeable Weight Gain / Loss

Complaints of Disproportionate Fatigue

Complaints of General Body Aches/Pains or "Growing Pains"

Allergies: Seasonal, Animal, Food, Medication, Other: _____

Weakened Immunity: Fevers, Ear Infections, Colds, Other Infections: _____

Digestive Upset: Spitting Up, Gastric Reflux, Stomach Aches, Diarrhea, Constipation

Diagnosis of Autism, ADD/ADHD, Learning Disorder(s), Emotional Issues, Mental Illness

Is there anything else you would like to discuss with the Doctor?: _____

Parent/Guardian Initials: _____

Name: _____

Date: _____

GENERAL HEALTH HISTORY:

When was your child's last visit with the Primary Care Physician: _____

If the diagnosis was not "In Good Health", what was wrong: _____

Has / does your child currently work with any of the following types of providers?:

Acupuncturist Naturopath/Homeopath Massage Therapist PT/OT Psychotherapist

Is your child currently seeing another provider for an acute or chronic condition?: Yes No

If yes, please list why: _____

Has your child been under the care of another Chiropractor in the past?: Yes No

If yes, please list why: _____

Has your child been brought to a hospital for any reason (other than birth)?: Yes No

If yes, please list why: _____

Please indicate if your child has had any of the following surgeries:

◇ Tonsils/Adenoids ◇ Sinus ◇ Ear Tubes ◇ Appendix ◇ Hernia ◇ Extremity ◇ Spine

Other: _____

Please indicate how often your child exercises: _____ **days / wk**

What type of exercise?: _____

Please tell me about your child's food and water intake:

How many oz of water is consumed daily: _____ What is your child's approx. weight: lb

If your child follows a special diet, please describe: _____

Please tell me about your child's bed:

What type of mattress?: Foam Coil Other: _____ How old is it?: yrs

Females only: Age at onset of first period: _____ Is your daughter's cycle regular: Yes No

QUALITY OF LIFE EVALUATION:

How do you rate your child's present **General Health**?: ◇ Excellent ◇ Good ◇ Fair ◇ Poor

How do you rate your child's ability to **Handle Stress**?: ◇ Excellent ◇ Good ◇ Fair ◇ Poor

How do you rate your child's overall **Quality of Life**?: ◇ Excellent ◇ Good ◇ Fair ◇ Poor

GOALS FOR CARE:

I hope to see the following benefits from Chiropractic Care: *(Check all that apply)*

- ◇ Relief of a symptom or problem
- ◇ Relief and Prevention of a symptom or problem
- ◇ Healthier spine and nervous system
- ◇ Optimal health overall

Parent/Guardian Initials: _____

Name: _____

Date: _____

FAMILY HISTORY

PLEASE LIST THE AGES OF THE FOLLOWING FAMILY MEMBERS (IF DECEASED, PLEASE LIST AGE AT DEATH):

Mother: _____ Father: _____ Living Grandparents: _____

Siblings: _____

PLEASE CIRCLE IF THE PATIENT OR AN IMMEDIATE FAMILY MEMBER HAS ANY OF THE BELOW LISTED CONDITIONS NOW OR IN THE PAST

MUSCULO / SKELETAL REVIEW:

Arthritis.....	Self	Parent	Sibling	Grandparent
Osteoporosis / Osteopenia	Self	Parent	Sibling	Grandparent
Headaches.....	Self	Parent	Sibling	Grandparent
Scoliosis.....	Self	Parent	Sibling	Grandparent
Neck Pain / Back Pain.....	Self	Parent	Sibling	Grandparent
Pain: Shoulder/Arm/Hand, Leg/Foot	Self	Parent	Sibling	Grandparent
Paralysis / Vertigo.....	Self	Parent	Sibling	Grandparent

SYSTEMIC REVIEW / NEUROLOGICAL DISEASE:

Cancer.....	Self	Parent	Sibling	Grandparent
Diabetes.....	Self	Parent	Sibling	Grandparent
Stroke / Epilepsy.....	Self	Parent	Sibling	Grandparent
Parkinson's / Alzheimer's / MS	Self	Parent	Sibling	Grandparent
Anxiety / Depression / ADD/ ADHD/ ODD	Self	Parent	Sibling	Grandparent

RESPIRATORY REVIEW:

Asthma / Lung Disease.....	Self	Parent	Sibling	Grandparent
Seasonal Allergies.....	Self	Parent	Sibling	Grandparent

CARDIAC REVIEW:

Heart Disease / Blood Pressure Issue.....	Self	Parent	Sibling	Grandparent
Circulatory Disease/Disorder.....	Self	Parent	Sibling	Grandparent

DIGESTIVE REVIEW:

Do you have a Bowel Movement daily	Yes / No
Allergies / Sensitivities(Food).....	Self Parent Sibling Grandparent
Excessive Thirst / Heartburn.....	Self Parent Sibling Grandparent
Frequent Nausea/Vomiting/Diarrhea/Constipation	Self Parent Sibling Grandparent

GENITO / URINARY REVIEW:

Kidney Stones / Infection / Frequent UTI.....	Self Parent Sibling Grandparent
Menstrual Symptoms / Reproductive Challenges	Self Parent Sibling Grandparent

REVIEW OF SYSTEMS & INFECTIOUS DISEASE:

Frequent Influenza/Pneumonia/Bronchitis	Self Parent Sibling Grandparent
Vision Problems/Eye Disease.....	Self Parent Sibling Grandparent
Dental Problems / TMJ.....	Self Parent Sibling Grandparent
Ear Infections / Hearing loss / Tinitis.....	Self Parent Sibling Grandparent
Fatigue / Disrupted Sleep.....	Self Parent Sibling Grandparent

Parent/Guardian Initials: _____

Name: _____

Date: _____

STRESS PROFILE (PAGE 5)

PEDIATRIC STRESS PROFILE:

THERE ARE THREE TYPES OF **STRESS** THAT WILL AFFECT THE **SPINE & NERVOUS SYSTEM:**
EMOTIONAL STRESS, CHEMICAL STRESS, AND PHYSICAL STRESS

EMOTIONAL STRESS:

Please indicate if your child has in the past or presently experiences any of the following emotional stressors:

- ◇ Chronic Illness (*self or family*) ◇ Childhood Trauma ◇ Abuse
- ◇ School Stress ◇ Loss of a Loved One ◇ Divorce / Separation

CHEMICAL STRESS:

Please indicate any exposure your child may have had to the following (past and/or present):

Daily Habits:

Caffeine: _____ oz/ day OTC: _____ /wk

Environmental Exposure:

- ◇ Second Hand Smoke ◇ Toxic Chemicals ◇ Radiation Therapy ◇ Chemotherapy

Medications:

- ◇ Aspirin/Pain Reliever ◇ Mood/Anxiety/Depression ◇ ADD/ADHD ◇ Insulin

◇ Vaccinations: Up to Date: _____ Other: _____ Any Reactions: _____

◇ Other Medications: _____

PHYSICAL STRESS:

Please answer the following to the best of your ability:

Repetitive Physical Stress:

How long does your child spend in front of an electronic device?: _____ hours/day

Where does your child do homework?: _____ How long does it take?: _____ hours

Major Trauma: Has your child:

- Been treated for any physical injuries in the past year?: ◇ No ◇ Yes
- Been a passenger in a car/truck/bus/train accident?: ◇ No ◇ Yes
- Experienced any Injuries during Sports or Gym Class?: ◇ No ◇ Yes
- Experienced a Slip & Fall, Trauma, Broken Bone?: ◇ No ◇ Yes
- Had x-rays/CT Scan/MRI (Other than dental visits)?: ◇ No ◇ Yes

Thinking back to infancy, has your child experienced any of the following physical traumas?:

(Studies show at least 50% of all children have fallen from a bed or other elevated surface, please be honest!!)

Fall from a bed / changing table / out of the crib: ◇ No ◇ Yes

Fall down stairs / off playground equipment / out of a tree: ◇ No ◇ Yes

Fall while using a bicycle, rollerblades, heelies, etc.: ◇ No ◇ Yes

Play on a trampoline or attend "bounce" parties/classes: ◇ No ◇ Yes

Parent/Guardian Initials: _____