Miano Family Chiropractic Center, LLC

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: _____

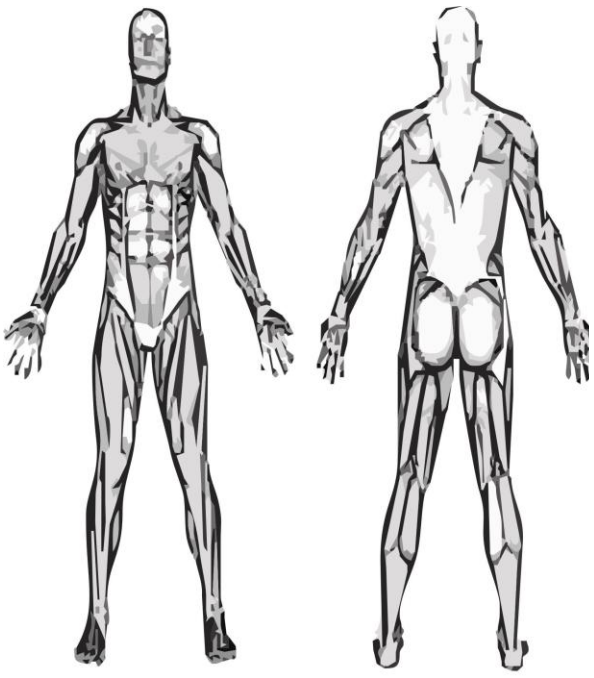
What makes your child worse: _____

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%) Intermiten (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 IT 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: _____ **CASE HISTORY (PAGE 2)**

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: _____ **CASE HISTORY (PAGE 3)**

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: _____ **CASE HISTORY (PAGE 4)**

EXTENDED FAMILY HISTORY

Please list the ages of the following family members *(If deceased, please list age at death)*:

Mother: _____ Father: _____ Living Grandparents: _____

Siblings: _____ _____ _____ _____ _____

Does your child have any of the below listed conditions now or in the past?

MUSCULO / SKELETAL ISSUES:

Yes No Arthritis
Yes No Osteoporosis
Yes No Osteopenia
Yes No Headaches
Yes No Scoliosis
Yes No Neck Pain
Yes No Mid-Back Pain
Yes No Lower Back Pain
Yes No Shoulder/Arm/Hand Pain
Yes No Leg/Foot Pain
Yes No Paralysis
Yes No Dizziness
Yes No Numbness / Tingling
Other: _____

SYSTEMIC / NEUROLOGICAL DISEASE:

Yes No Cancer
Yes No Diabetes
Yes No Stroke
Yes No Epilepsy
Yes No Parkinson's Disease
Yes No Alzheimer's Disease
Yes No Multiple Sclerosis
Yes No Mental Health Issue
Yes No Anxiety / Depression
Yes No ADD/ADHD/ODD
Other: _____

RESPIRATORY ISSUES:

Yes No Asthma / Lung Disease
Yes No Frequent Pneumonia / Bronchitis
Yes No Seasonal Allergies
Other: _____

CARDIAC ISSUES:

Yes No Heart Disease
Yes No Chest Pain/Heart Attack
Yes No High/Low Blood Pressure
Yes No Circulatory Disease/Disorder
Other: _____

DIGESTIVE ISSUES:

Yes No Do you have a Bowel Movement daily
Yes No Allergies/Sensitivities(Food)
Yes No Poor/Excess Appetite
Yes No Excessive Thirst
Yes No Frequent Nausea/Vomiting
Yes No Heartburn
Yes No Diarrhea/Constipation
Other: _____

GENITO / URINARY ISSUES

Yes No Kidney Stones / Infection
Yes No Bladder Infection
Yes No Reproductive Problems
Yes No Yeast Infections
Other: _____

REVIEW OF SYSTEMS & INFECTIOUS DISEASE:

Yes No Tuberculosis
Yes No Influenza / Pneumonia
Yes No Vision Problems/Eye Disease
Yes No Dental Problems / TMJ
Yes No Frequent Ear Infections
Yes No Loss of Hearing/Tinitis
Yes No Loss of Smell
Yes No Fatigue / Loss of Sleep
Other: _____

_____

Parent/Guardian Initials: _____

Name: _____ Date: _____ CASE HISTORY (PAGE 5)

PEDIATRIC STRESS PROFILE:

Chiropractors are trained to detect and correct imbalance of the **SPINE & NERVOUS SYSTEM**.

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: _____