CHILD HISTORY FORM

TODAY'S DATE: _____/_____/_____

NAME: ____ DATE OF BIRTH: ____/____/____

ADDRESS: ____ PHONE #:___________________

CITY/STATE/ZIP: __________________________________ REFERRED BY: ______________________

PEDIATRICIAN'S NAME: _________________________________ PHONE #: _______________________
DATE OF LAST VISIT:______________ REASON FOR LAST VISIT: ___________________________________
PREVIOUS CHIROPRACTOR'S NAME: _______________________________ PHONE #:_________________
DATE OF LAST VISIT: ____________ REASON FOR LAST VISIT:____________________________________

AUTHORIZATION FOR CARE OF A MINOR
PARENT(S) NAME(S): __________________________________ WORK PHONE #: ____________________
I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE:__________________________________ WITNESS:__________________

CHIEF HEALTH CONCERNS
Reasons for contacting us: ____
List other care received for this complaint, including medication:______________________________
____
Date of Onset: ____/____/____ Onset was: Sudden / Gradual / Associated with an event
Duration of problem (episode): ____________ minutes / hours / days / months / years
Pattern of problem: Constant / Intermittent / Occasional / Cyclical
Initiating factors:____
Aggravating factors:____
Relieving factors:____
Effects of problems on body function and daily activities: _______________________________________
Prior occurrence or episodes: ____

OTHER HEALTH CONCERNS:____
____

HISTORY OF BIRTH

Hospital: Birthing Center / Home / Medical / Midwife

Duration of Gestation: _________ weeks Assisted Birth? No / Yes If yes: Forceps / Vacuum / Extraction / C-Section / Induced Labor

Medications delivered to mother at birth? No / Yes If yes, what? ______________________________

Duration of birth: ____

Complications at birth? No / Yes Explain: ____

Was delivery normal? No / Yes Explain: ____

APGAR at birth: _____________ After 5 minutes: ___________ Birth weight: __________ Birth length: ____________

GROWTH & DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? No / Yes Explain:______________________

At what age did the child: Respond to sound? ___________ Follow an object? __________ Hold up head?___________

Vocalize?_______ Sit alone? _________ Teethe?_________ Crawl?________ Walk? __________

Do sleeping patterns seem normal to you? No / Yes Explain: ______________________________________

Any health problems(cancer, diabetes, heart disease, etc.) on the mother's side of the family?_________________

On the father's? ________________________ With siblings? ______________________________

Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us.

CHEMICAL STRESSORS:

Was the baby breast-fed? No/Yes How long? ____________________________

Formula introduced at age: _____ Type of formula used: ______________________ Cow's milk introduced at age: _______

Began solid foods at age: _____ Type: ______________ Age and type of commercial baby food introduced: __________

____

Food / Juice intolerance? No / Yes Type:____

During Pregnancy did the mother smoke? No / Yes Did the mother drink alcohol? No / Yes

Any illness of mother during pregnancy?____

Any supplements taken by mother during pregnancy?____

Any drugs taken during pregnancy?____

Any exposure to ultrasound? No / Yes If so, how many and for what medical reason? ____________________________

Any invasive procedures(amniocentesis, VCS): ____

Any pets at home? No / Yes ____

Any smokers at home? No / Yes If so, how much? ____

Any vaccinations? No / Yes Which ones and any reactions?____

Any antibiotics: No / Yes Explain: ____

Total number of courses of antibiotics to date:____

PSYCOSOCIAL STRESSORS:

Any difficulties with lactation? No / Yes ____

Any problems with bonding? No / Yes ____

Any behavioral problems? No / Yes Onset?____

Any night terrors, sleep walking, difficulty sleeping? No / Yes Exlpain:____

Age of child when began daycare: ___________ Average number of hours of television per week:__________________

Does your child seem normal for their age? No / Yes Explain:____

TRAUMATIC STRESSORS:

Any trauma during pregnancy (falls, accidents):____

Any evidence of birth trauma (bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other) ____

Any falls from bed, changing table, stroller? ____

Any traumas with bruising, cuts, stitches, fractures? ____

Any hospitalizations? No / Yes Explain: ____

Any surgeries or organs removed? ____

Sports played and age began:____

Number of hours per week played:____

Weight of school backpack: ________________ Approximate hours spent at play per week: ____________

Thank you for completing this form. Please write any other questions you have below.

CHILD'S NAME: ____________________________ D.O.B. _____ / _____ / _____