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. _____ / _____ / _____