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PEDIATRIC HISTORY FORM

(NEWBORN up to 5 Years Old)

Child's Name: ______________________________ ☐ Male ☐ Female **Today's Date:**_______________

Age:_______________________________________ **Birthdate:**______________________________________

Parent's Name:____ Date:_______________________
Address:____
Home Telephone:______________________________Work Telephone:______________________________
Parent's Social Security#:________________________Driver's Lic#_________________________________
Occupation/Employer's Name and address____
Single______Married______Divorced______Widowed______
Spouse's Name____
Spouse's Occupation/Employer:____
No. of children:________
Reason for Consulting our Office?____
Who may we Thank for referring you to our office?____

YOUR CHILD'S HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on you and your child's ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses your child has faced in during his/her lifetime, allowing us to better assess the challenges to your child's health potential.

THE REASON FOR YOUR VISIT IS: (PLEASE CHECK ALL THAT APPLY)

☐ Wellness – I just want my child to have a spinal checkup.
☐ Pain / Symptom – Please use the space below to tell us more:

- When did it start?____
- How long has it been going on? ____
- Is it a Pain or other symptom? How would you describe it?_________________________
  ____
  ____
- What have you tried to this point to help?______________________________________
- Have you taken your child to the pediatrician for this issue? ___Y ____N
  If yes, who is your child's pediatrician?___________________________________
  Is there any other information we should regarding this issue? ______________________
  ____
  ____

THE BEGINNING YEARS
Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some staring at birth. Please answer the following questions to the best of you ability.

BIRTHING PROCESS:

- Hospital/Birthing Center: □ Home □ Medical □ Midwife
- Duration of Pregnancy: __________weeks
- Were any other means used during the birthing process:
  □ NO □ YES,circle? Induced Forceps Vacuum Extraction C-section Other___________
- Duration of Birth:________________
- Medications delivered at birth: □ NO □YES,explain? ____
- Was Delivery Normal? □ YES □ NO, explain?____

* APGAR at birth_______________ After 5 mins.____________

* BIRTH WEIGHT: ___________ BIRTH LENGTH:______________

GROWTH AND DEVELOPMENT:

* Was the infant alert and responsive within twelve hours of delivery □YES □NO, 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 to be normal? □YES □ NO, explain?__________________________________

* Any health problems on the mother's side of the family? □ NO □ YES, explain?______________________

On father's side of the family? □ NO □YES, explain?____

With brothers or sisters? □ NO □ YES, explain? ____

Allergies? If so, list them here: ____

SINCE MANY PROBLEMS CAN BE RELATED TO MANY TYPES OF STRESSORS, THE FOLLOWING INFORMATION IS VERY IMPORTANT….

PHYSICAL/TRAUMATIC STRESSORS:

* Any traumas during pregnancy(falls, accidents)?____

* Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, discoloration, cord around neck, other_________________

* Any falls from couches, beds, changing tables, chairs? □ NO □ YES, explain?______________________

____

* Any surgeries? □ NO □ YES, explain?____

* Any sports? □ NO □ YES, explain?____

CHEMICAL STRESSORS:

* Was this baby breast-fed? □ NO □ YES, how long?__________

* Formula introduced at age_______ Type of formula used______

* Introduction to cow's milk at age_____ Began solid foods at age______

* Type of solid food_______________ Commercial baby food introduced_____________________

*FOOD/JUICE intolerance □ NO □ YES,explain?____

* During pregnancy did the mother:
smoke? □ NO □ YES drink alcohol? □ NO □ YES drink caffeine? □ NO □YES

* Any illnesses of the mother during pregnancy? □ NO □YES, explain?____________________________

* Any supplements during pregnancy? □ NO □ YES, explain?_____________________________________

* Any drugs (prescription, over-the-counter, recreational) taken during pregnancy? □ NO □ YES,__________

* Any ULTRASOUNDS during pregnancy? □ NO □ YES, how many and list medical reason?___________

* Any invasive procedures (amniocentesis)? □ NO □ YES, list?____________________________________

* Any pets at home? □ NO □ YES, what kind and how many?____________________________________

* Any smokers that live in the home? □ NO □ YES, explain?_____________________________________

* Any Vaccinations? □ NO □ Yes – ALL to Date □ Yes - Some, List ______________________________

Any antibiotics use □ NO □ YES, when was first course of antibiotics given?______________________

TOTAL number of courses of antibiotics give to date?____

EMOTIONAL/PSYCHOSOCIAL STRESSORS:

Any difficulties with lactation? □ NO □ YES

Any problems with bonding? □ NO □ YES

Any behavioral problems? □ NO □ YES, when did they begin?________________________________

Any difficulty sleeping? □ NO □ YES,explain?

Age when child began daycare?___________

Average number of hours of television per week?_____________

Does your child seem normal for his/her age? □ YES □ NO,explain?__________________________

Please list any additional information you would like us to know about your child:

____

____

____

______________________________ ____________________________ ____________

Parent/Guardian (**PRINT NAME**) Parent/Guardian (**SIGNATURE**) **DATE**