**PEDIATRIC HEALTH HISTORY FORM**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_ Sex: M F

Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling(s)[names and ages]:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date physician was last seen: \_\_\_\_\_\_\_\_\_

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| **CURRENT HEALTH CONDITIONS** |

Describe the purpose of this visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the condition first begin? \_\_\_\_\_\_\_\_\_\_\_ Has this condition occurred before? Yes □ No □

How did the problem start? Suddenly □ Gradually □ Post Injury □ Other □ \_\_\_\_\_\_\_\_\_\_\_

Has your child received care for this condition before? Yes □ No □

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition: improving □ getting worse □ intermittent □ constant □ unsure □

What makes the problem better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes the problem worse?\_\_\_\_\_\_\_\_\_\_

Have you ever visited a chiropractor? Yes □ No □

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| **PREGNANCY & FERTILITY HISTORY** |

Please tell us about your pregnancy

Any fertility issues? Yes □ No □ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did mother smoke? Yes □ No □ If yes, how many per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did mother drink? Yes □ No □ If yes, how many per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did mother exercise? Yes □ No □ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was mother ill? Yes □ No □ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain any notable mental or physical stress during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain any other concern’s or notable remarks about your child’s conception or pregnancy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **LABOR & DELIVERY HISTORY** |

Child’s birth was: natural vaginal birth □ scheduled C-section □ emergency C-section □

At how many weeks was your child born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any applicable interventions or complications:

breech □ induction □ pain meds □ epidural □ episiotomy □ vacuum extraction/forceps □ other □

Please describe any other concerns or notable remarks about your child’s labor and/or delivery:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s birth weight: \_\_\_\_\_lbs \_\_\_\_\_oz Child’s birth height:\_\_\_\_\_in

APGAR score at birth: \_\_\_\_\_\_ APGAR score after 5 minutes: \_\_\_\_\_

– OVER –

**PEDIATRIC HEALTH HISTORY FORM**

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| **GROWTH & DEVELOPMENT HISTORY** |

Is/was your child breastfed? Yes □ No □ If yes, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty with breast feeding? Yes □ No □ If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did/does your child ever suffer from colic, reflux or constipation? Yes □ No □

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes □ No □

At what age did the child: Respond to sound:\_\_\_\_ Follow an object:\_\_\_\_ Hold their head up:\_\_\_\_

Vocalize:\_\_\_\_ Teethe:\_\_\_\_ Sit alone:\_\_\_\_ Crawl:\_\_\_\_ Walk:\_\_\_\_

Please list any food intolerance or allergies and when they began:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your child’s hospitalization and surgical history, including the year:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major injuries, accidents, falls and/or fractures your child has sustained:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Night terrors or difficulty sleeping? Yes □ No □ If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral or emotional issues? Yes □ No □ If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY MEDICAL HISTORY** |

Please check if any blood relatives had any of the following illnesses and mark accordingly by noting:

M (mother); F (father); S (sibling); PGM (paternal grandmother); MGM (maternal grandmother)

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| \_\_\_\_\_ Allergy | \_\_\_\_\_ Eczema/Psoriasis | \_\_\_\_\_ Mental Illness |
| \_\_\_\_\_ Asthma | \_\_\_\_\_ Heart Trouble | \_\_\_\_\_ Scoliosis |
| \_\_\_\_\_ Birth Defect | \_\_\_\_\_ High Blood Pressure | \_\_\_\_\_ Seizures/Epilepsy |
| \_\_\_\_\_ Cancer | \_\_\_\_\_ Kidney Disease | \_\_\_\_\_ Stroke |
| \_\_\_\_\_ Diabetes/low blood sugar | \_\_\_\_\_ Liver Disease | \_\_\_\_\_ Ulcer |
| \_\_\_\_\_ Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **ADDITIONAL COMMENTS/CONCERNS** |

Please utilize the space below to write any other comments/concerns you may have about your child and his/her health history or that you wish the doctor to be aware of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_