INFANT/TODDLER PEDIATRIC PATIENT HEALTH HISTORY

PATIENT INFORMATION: **Date: _____**

Child's Name:_____ Mother's Name:_____

Child's Birthday: ____ / ____ / _____ Father's Name:_____

Street Address: _____

City:_____ State: _____ Zip:_____

Home #:_____ Mother's Cell #:_____ Mother's Work #:_____

Father's Cell #:_____ Father's Cell #:_____

Email:_____

Sex: ○ Male ○ Female Number of Siblings:_____ Current Weight:_____

Birth Weight: _____ lb _____ oz Birth Length: _____ in Current Height/Length: _____

PURPOSE OF THIS VISIT: _____

BIRTH STORY:

Third Trimester Presentation: ○ Vertex ○ Breech ○ Transverse ○ Face/Brow

Location of Birth: ○ Home ○ Hospital ○ Birthing Center

Type of Birth: ○ Normal Vaginal ○ Forceps ○ Cesarean ○ Suction Cup or Vacuum

How long was the pushing (in minutes): _____ *How many hours was the labor?*: _____

What was the total APGAR score (5 minutes after birth, 10 is perfect)? _____

At how many weeks was the child born (gestational age in weeks)? _____

Please check any evidence of birth trauma: ☐ Bruising ☐ Cord around neck ☐ Respiratory depression
☐ Fast or excessively slow birth ☐ Stuck in birth canal ☐ Odd shaped head ☐ OTHER

Infant feeding: ☐ Breastfed ☐ Formula-fed ☐ Unknown *Was cow's milk introduced?* ○*Yes* ○*No*

Has solid food been introduced? ○ Yes ○ No

Were any nutritional supplements prescribed or taken during pregnancy? ○ Yes ○ No ○ Unsure

Was ultrasound(s) performed during pregnancy? ○ Yes ○ No ○ Unsure

Were any invasive procedures performed during the pregnancy (Amniocentesis, Cerclage, etc)? ○ Yes ○ No ○ Unsure

Were there any significant falls or traumas to the mother during pregnancy? ○ Yes ○ No ○ Unsure

Did the mother suffer any illnesses during the pregnancy? ○ Yes ○ No ○ Unsure

During the pregnancy, did the mother do any of the following?:

☐ Smoke ☐ Drink Alcohol ☐ Use recreational drugs ☐ Unknown ☐ NONE

Were there any areas in which the child's achievement of developmental goals that were DELAYED? Choose all that apply.

☐ None, all developmental goals were met on schedule

☐ Delayed response to sound ☐ Delayed ability to follow an object ☐ Delayed normal appearance of teeth

☐ Delayed ability to crawl ☐ Delayed ability to walk ☐ Delayed ability to hold head up

☐ Delayed ability to vocalize ☐ Delayed ability to sit alone ☐ Unsure

☐ OTHER _____

PATIENT HISTORY AND BEHAVIORS:

Which vaccines has the child had to date? Choose all that apply. If all vaccinations are up to date, select "Received all childhood vaccinations on schedule."

☐ Received all childhood vaccinations on schedule
☐ Was NOT vaccinated

☐ Diphtheria (separate)	☐ DTP (Diphtheria, Tetanus, Pertussis)	☐ Haemophilius Influenza type B (HbCV)
☐ Hepatitis B (HBV)	☐ Human Papillomavirus (HPV, Gardasil)	☐ Influenza (flu)
☐ Measles (separate)	☐ MMR (combination)	☐ Mumps (separate)
☐ Neisseria Meningitis	☐ Pertussis (separate)	☐ Pneucoccus (separate)
☐ Polio (OPV, IPV)	☐ Rubella (separate)	☐ Tetanus (separate)
☐ Varicella	☐ OTHER	

Does the child have currently or has the child ever had (choose all that apply):

☐ *No problems*

☐ Acid Reflux	☐ Anemia	☐ Arm or shoulder condition
☐ Autism	☐ Broken bones	☐ Cerebral palsy
☐ Colic	☐ Congenital abnormalities	☐ Colds/Flu
☐ Constipation	☐ Cyanosis (blue) at birth	☐ Diarrhea
☐ Difficulty eating	☐ Difficulty walking	☐ Dizziness
☐ Down's syndrome	☐ Ear infection (chronic)	☐ Epilepsy
☐ Febrile convulsions	☐ Fever	☐ Foot flare
☐ Headaches	☐ Hearing difficulties	☐ Heart problems
☐ Hypertension	☐ Inability to thrive	☐ Jaundice (__ at birth or __ at other time)
☐ Poor appetite	☐ Scoliosis	☐ Seizures
☐ Sinus trouble	☐ Speech difficulties	☐ Stomach aches
☐ Torticollis	☐ Vision difficulties	
☐ OTHER		

Has the child ever experienced any of the following traumas? Choose all that apply.

☐ Fall in baby walker	☐ Fall from crib	☐ Fall from highchair	☐ Fall from changing table
☐ Fall from bed/couch	☐ Fall off swing	☐ Fall off slide	☐ Fall down stairs
☐ OTHER			

Has the child suffered from any of the following childhood diseases? If so, at what age?

☐ Chickenpox age_____	☐ Mumps age_____	☐ Measles age_____
☐ Rubella age_____	☐ Rubeola age_____	☐ Whooping Cough age_____

General Questions

Does the child have any allergies or intolerances (food or non-food)? ○ Yes ○ No ○ Unsure

*If yes, what allergies or intolerances does the child have?*_____

Has the child had any adverse reactions to vaccinations or medicines? ○ Yes ○ No ○ Unsure

Is there any history of antibiotics given to the child? ○ Yes ○ No ○ Unsure

Does the child have any history of serious falls or injuries, including factures, concussions, hospitalizations, etc.?
○ Yes ○ No ○ Unsure

Has the child ever sustained injuries in an auto accident? ○ Yes ○ No ○ Unsure

If yes, explain: _____

Are there any pets in the child's home? ○ Yes ○ No ○ Unsure

Are there any smokers in the child's home or environment? ○ Yes ○ No ○ Unsure

On average, how many hours per week of television/computer/smart phone interaction does the child have? _____ hrs

How many hours of sleep does the child get per night? _____ Quality of sleep: ○ Good ○ Fair ○ Poor

Do you feel the child's social and emotional development is normal for their age? ○ Yes ○ No ○ Unsure

Have there been any difficulties with child-parent bonding? ○ Yes ○ No ○ Unsure

Does the child have any behavioral problems? ○ Yes ○ No ○ Unsure

PATIENT HISTORY AND BEHAVIORS (cont.):

Have any of the following behaviors occurred? Check all that apply.

☐ None	☐ Attention issues	☐ Difficulty sleeping
☐ Failure to maintain eye contact	☐ Hearing issues	☐ Night terrors
☐ Unsure	☐ OTHER	

Please list any medications the child is currently taking, including frequency and dosage, if known. If there are no current medications, please check this box ☐.

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Please list the child's past surgical history. Indicate the age of the child at the time of surgery.

1) _____ 2) _____

3) _____ 4) _____

CHIROPRACTIC EXPERIENCE AND GOALS FOR CARE:

How did you hear about our clinic? Or who referred you?

☐ Facebook ☐ Website ☐ Sign on building ☐ Community Event ☐ Parent is a patient

☐ Another Provider _____ ☐ Existing Patient _____

☐ Phone Book (which one? _____) ☐ Other _____

Has the child been adjusted by a chiropractor before? ○ **Yes** ○ **No** If yes, why? _____