MINOR 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:_____

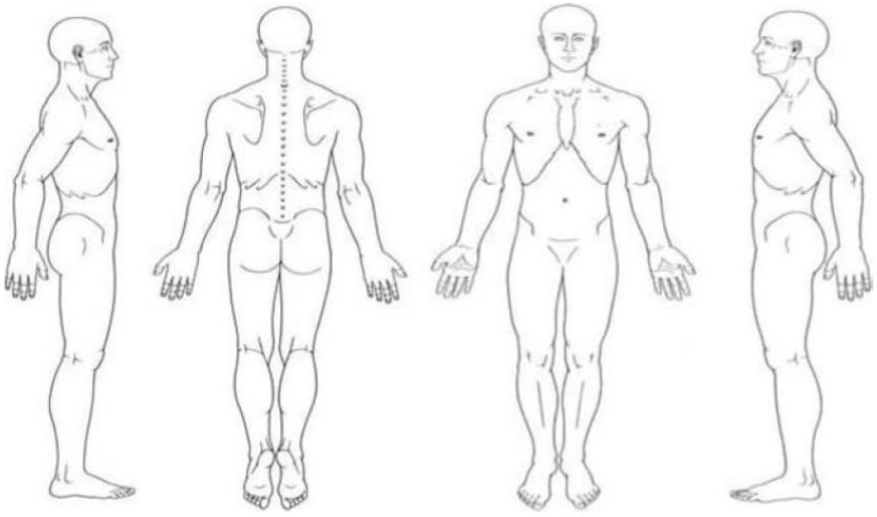
Sex: ○ Male ○ Female Number of Siblings:_____

Current Height/Length: _____ Current Weight:_____

What is the purpose of this visit? **_____**

Using the key below, indicate on the diagram the type/location of symptoms.

= Numbness
* = Pain
X = Burning
/ = Stabbing
0 = Pins/Needles
+ = Dull Ache



What caused these symptoms? _____

When did these symptoms begin? _____

What activities make the symptoms worse? _____

What, if anything, makes the symptoms better? _____

PATIENT HISTORY AND BEHAVIORS:

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

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

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	☐ ADD
☐ ADHD	☐ Anemia	☐ Arm or shoulder condition
☐ Asperger's	☐ Asthma	☐ Autism
☐ Backaches	☐ Broken bones	☐ Cerebral palsy
☐ Colds/Flu	☐ Congenital abnormalities	☐ Constipation
☐ Cyanosis (blue) at birth	☐ Diabetes	☐ Diarrhea
☐ Difficulty eating	☐ Difficulty walking	☐ Dizziness
☐ Down's syndrome	☐ Ear infection (chronic)	☐ Epilepsy
☐ Fainting	☐ Febrile convulsions	☐ Fever
☐ Foot flare	☐ Headaches	☐ Hearing difficulties
☐ Heart problems	☐ Hypertension	☐ Jaundice (__ at birth or __ at other time)
☐ Joint problems	☐ Poor appetite	☐ Poor posture
☐ 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 from bed/couch	☐ Fall off swing	☐ Fall off slide	☐ Fall off monkey bars
☐ Fall off skateboard/skates	☐ Fall off bicycle	☐ 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

Does the child participate in **sports or exercise activities**?
○ No ○ Contact and non-contact sports ○ Non-contact sports only (gymnastics, running) ○ Unsure ○ OTHER

If the child is in sports, have they ever sustained an injury playing organized sports? ○ *Yes* ○ *No* ○ *Unsure*

If yes, explain: _____

Does the child engage in any hobbies or activities which **require prolonged, awkward or repetitive postures** (violin, gymnastics, ballet, etc.)? ○ Yes ○ No ○ Unsure

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

If yes, explain: _____

Does the child wear a backpack? ○ Yes, light backpack ○ Yes, heavy backpack ○ No ○ Unsure ○ Other

PATIENT HISTORY AND BEHAVIORS: (continued)

General Questions (continued)

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

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

For female patients: Has the child menstruated? ○ Yes ○ No ○ Unsure

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

☐ None	☐ Bedwetting	☐ Difficulty sleeping
☐ Failure to maintain eye contact	☐ Hearing issues	☐ Nervous tics
☐ Night terrors	☐ Sleepwalking	☐ Stutter or stammer
☐ Attention issues	☐ 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? _____