Body in Balance Chiropractic

PEDIATRIC HEALTH HISTORY

Parent's Name: _____ Date:_____

Child's Name: _____ Date of Birth:_____

Sex: _____ Siblings Names and Ages: _____

_____

Email Address:_____

Mailing Address: _____

Phone Number: _____

Pediatrician and Contact Information: _____

Has your child ever received chiropractic care?_____

Date and reason for last visit to Doctor? (DC or MD) _____

Other professionals seen for this reason? _____

Results with previously given treatment? _____

Recent tests done (Blood work, urine analysis, x-rays, other) Please explain and include dates: _____

_____

_____

What is the purpose for your child's visit? _____

_____

PRESENT HEALTH CONCERNS

What is the present health concern(s), if any? _____

_____

When did the problem begin? _____

Is it occasional/frequent/intermittent/constant? _____

Does the pain radiate? If so, where? _____

What makes it feel better? _____

What makes it feel worse? _____

Does this issue interfere with the child's eating/sleep/daily routine? _____

Is the problem worse during a certain time of day? If yes, when? _____

Is it getting any better or worse? _____

Often seemingly unrelated symptoms can manifest as other health concerns. Please circle if your child has had any of the following:

Headaches	Dizziness	Irritability	Fatigue
Depression	Loss of Balance	Buzzing in Ears	Fainting
Loss of Concentration	Poor Coordination	Vision Changes	Loss of Memory
Loss of Smell or Taste	Light Sensitivity	Flushed Face	Reduced Mobility
Chest Pressure	Frequent Colds	Sinus Congestion	Sore Throat
Ear Pain/Infection	Asthma	Cold Sweats	Bronchitis
Pneumonia	Difficulty Breath	Shortness of Breath	Allergies
Constipation	Diarrhea	Urinary Problems	Bloating/Gas
Weight Loss	Weight Gain	Dental Problems	Fevers
Heart Palpitation	Heart Murmur	Numbness in hands or feet	Weakness
Heartburn	Muscle Cramps	Upper Back Pain	Lower Back Pain
Neck Pain	Radiating Pain	Sleeping Problems	Stiffness

Any other concerns not shown above? _____

_____

BIRTH HISTORY

What was the child's gestational age at birth? Birth weight? Birth Length? _____

_____

Where was your child's birth? (Home, Birthing center, Hospital, Other) _____

Was the birth considered medical or by midwife? _____

What was the duration of the birthing process in hours? _____

Was the baby born cephalic (head first) or breech (feet first)? _____

Were there any complications? If yes, please explain. _____

_____

Assistances during delivery: (Forceps, Vacuum extraction, C-section, Episiotomy) _____

_____

Was labor spontaneous or induced? _____

Were medications or epidurals given to the mother during birth? _____

APGAR score at birth _____ / 10? APGAR score after 5 minutes _____ / 10?

Is there anything else we need to know about the birthing process? _____

_____

GROWTH AND DEVELOPMENT

At what age did the child: respond to sound, hold up head, sit alone, crawl, follow an object, vocalize, teethe, and walk. _____

_____

_____

Does your child sleep on their stomach, back or side? _____

Do you consider the child's sleeping pattern normal? (YES / NO)

How many hours of sleep does the child get per night? _____

FAMILY HISTORY

Please note any and all health problems (ie: cancer, diabetes, hypertension, heart disease, hereditary disorders) that are present in the mother's family, father's family, and siblings:

_____

_____

_____

_____

_____

PHYSICAL STRESSORS

Any evidence of birth trauma to the infant? Please list if there was any of the following: bruising, stuck in birth canal, respiratory depression, odd shaped head, fast or excessively long birth, or cord around neck.

_____

_____

_____

_____

Any falls from couches, changing table, bed etc? (If yes, please explain)

_____

_____

Any trauma resulting in bruises, cuts, fracture, or stitches? (please explain)

_____

_____

_____

Any surgeries or hospitalizations? (If yes, please explain).

_____

_____

_____

Any sports played? _____

Is a school backpack used? Is it heavy or light? _____

CHEMICAL STRESSORS

Was the child breast-fed? If yes, for how long? _____

Was formula introduced? If yes, at what age and which formula? _____

_____

Was cow's milk introduced? If yes, at what age? _____

What age did the child start solid foods? What foods? _____

_____

Any food/juice intolerance? (If yes, please explain) _____

_____

Is your child on or ever taken any medications? (if yes, what medications) _____

_____

During the pregnancy did the mother smoke? (if yes, how much?) _____

During the pregnancy did the mother drink alcohol? (If yes, how much?) _____

Any illnesses during the pregnancy? (if yes, please explain) _____

_____

Any supplements taken during the pregnancy? (if yes, please specify) _____
_____

Any medications/drugs taken during the pregnancy? (if yes, please specify) _____
_____

Any ultrasounds during pregnancy? If yes, how many and for what reason? _____
_____

Any invasive procedures during pregnancy? (ie amniocentesis, Chronic villi sampling, etc) If yes, please describe. _____
_____

Any pets at home? _____

Any smokers in the house? _____

Any antibiotics taken by child? If yes, for what reason(s)? _____
_____

Please describe your child's diet (organic foods, processed foods, dairy, grains etc) _____
_____
_____

Are you aware of the impact of nutrition on children's behavior?	YES	NO
Would you like information on nutrition for your child?	YES	NO

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation?	YES	NO
Any problems with bonding at birth?	YES	NO
Any behavioral problems?	YES	NO
Trouble with inattention?	YES	NO
Any hyperactivity or restlessness?	YES	NO
Any compulsiveness?	YES	NO
Any difficulties at daycare/school?	YES	NO
Any learning deficiencies/delays?	YES	NO
Difficulty with sleep?	YES	NO
Prolonged temper tantrums?	YES	NO
Separation anxiety?	YES	NO

Thank you for completing the health history form. Your child's healthy future starts here!