TRIAD HEALTH CENTER PEDIATRIC HISTORY FORM

PATIENT (CHILD) DEMOGRAPHICS Today's Date ______________________ HR#:________________

Child's Name____ Gender: M | F DOB ______________________

Address ____ City ________________________ State ________ Zip _________________

Mother's Name ____ Mother's Phone ____

Father's Name ____ Father's Phone _______________________________________

Birth Height: ____________ Birth Weight: _____________ Current Height: _____________ Current Weight: _____________

Pediatrician/Family MD ____ Last Visit Date ________________________________

Authorized Parent/Guardian ____ Phone _________________________________

Email ____

Whom may we thank for referring you? ____

CHILD'S CURRENT HEALTH CONDITIONS:

Purpose of today's visit: ☐ Wellness Evaluation ☐ Injury or Accident ☐ Other: _______________________________________

When did the complaint first begin? Date ________________________ ☐ Unknown ☐ Gradual ☐ Sudden ☐ Post-injury

Has your child experienced this complaint before? **Y | N** *If yes, when?* ____

Has your child had any past treatment for this complaint? **Y | N** *Describe:* ____

____

What were the results of past treatment? ____

How is this problem now? ☐ Rapidly improving ☐ Improving slowly ☐ About the same ☐ Gradually worsening ☐ On & off

Please list any medication taken for this problem ____

Any other current medications ____

Any bowel or bladder problems since this problem began?: **Y | N** *Describe:* ____

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child?

1) ____

2) ____

3) ____

What would you like to gain from Chiropractic Care? ☐ Resolve existing condition ☐ Overall wellness ☐ Both ☐ Other:

Explain ____

Have you ever visited a chiropractor? **Y | N** *What is their specialty?* ☐ Pain Relief ☐ Physical therapy/rehab

☐ Nutritional ☐ Subluxation-based ☐ Other ____

PREGNANCY & BIRTH HISTORY

At how many weeks was your child born? ____

Describe any pregnancy complications and when they occurred ____

____

Tell us about this child's delivery: ☐ Hospital ☐ Obstetrician ☐ Birthing Center ☐ Home birth ☐ Midwife

☐ Vaginal birth ☐ Emergency C-section ☐ Scheduled C-section ☐ Breech ☐ Forceps used ☐ Vacuum Extraction

☐ Induction ☐ Epidural ☐ Pain meds ☐ Episiotomy ☐ Meconium Aspiration Syndrome ☐ Other ________________________

Any additional detail about Labor / Delivery: ______________________________

____

FEEDING HISTORY

Child was: ☐ Breastfed *How long?* ______________ ☐ Formula Fed *How long?* ______________

Introduced to: Solid foods at ________ months old. Cow's milk at ________ months old.

Known food allergies / intolerances: ______________________________

How would you rate your child's diet? ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amounts of processed foods

CHILDHOOD DISEASES

Chicken Pox **Y | N** *Age* ________ Rubeola **Y | N** *Age* ________ Whooping Cough **Y | N** *Age* ________

Rubella **Y | N** *Age* ________ Mumps **Y | N** *Age* ________ Other ______________ *Age* ________

DEVELOPMENTAL HISTORY

During the following times your child's spine is the most vulnerable to stress and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of spinal nerve interference. At what age was your child able to:

Respond to sound *Age* ________ Sit up alone *Age* ________ Walk alone *Age* ________

Respond to visual stimuli *Age* ________ Cross crawl *Age* ________ Vocalize *Age* ________

Hold head up alone *Age* ________ Stand alone *Age* ________ Teethe *Age* ________

Has your child fallen from a high place (ie: a bed, changing table, stairs, chair, etc)? **Y | N**

Is / has your child been involved in any high impact or contact type sports (ie: soccer, football, gymnastics, baseball, hockey, cheerleading, martial arts, etc)? **Y | N**

Has your child ever been involved in a car accident? **Y | N** *Explain:* ______________________________

Any other traumas not described above? ______________________________

Any surgeries? **Y | N** *Explain, including year:* ______________________________

REVIEW OF SYSTEMS

Has your child ever had any of the following:

Y | N Headaches
Y | N Orthopedic Problems
Y | N Digestive Problems
Y | N Behavioral Problems
Y | N Dizziness
Y | N Neck Problems
Y | N Poor Appetite
Y | N ADD/ADHD
Y | N Fainting
Y | N Arm Problems
Y | N Stomach Aches
Y | N Ruptures/Hernia
Y | N Seizures/Convulsions
Y | N Leg Problems
Y | N Reflux
Y | N Muscle Pain

Y | N Heart Trouble
Y | N Joint Problems
Y | N Constipation
Y | N Growing Pains
Y | N Earaches
Y | N Backaches
Y | N Diarrhea
Y | N Sinus Trouble
Y | N Poor Posture
Y | N Hypertension
Y | N Asthma
Y | N Scoliosis
Y | N Anemia
Y | N Colds/Flu
Y | N Walking Trouble
Y | N Bed Wetting

Y | N Colic
Y | N Broken Bones
Y | N Sleep Problems
Y | N Night Terrors
Y | N Torticollis
Y | N Learning Difficulties
Y | N Ear Infections
Y | N PDD / Autism
Y | N Acid Reflux
Y | N Hip Dysplasia
Y | N Tonsillitis
Y | N Frequent Fever
Y | N Seasonal Allergies
Y | N Allergies to ______________

____

Other: ______________________________

Your child sleeps: ______ hours per night ______ hours per day/naps *Sleep quality:* ☐ Good ☐ Fair ☐ Poor

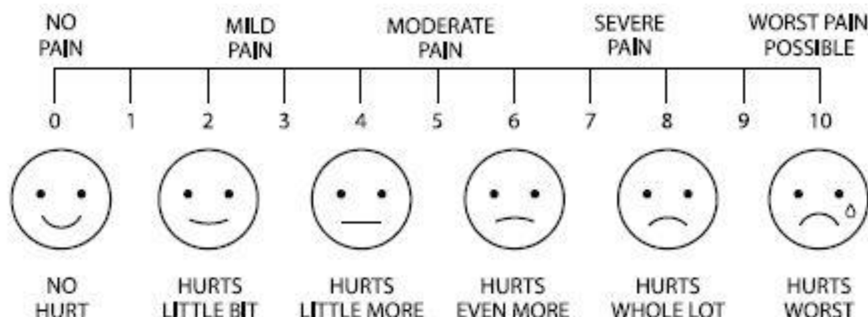
Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed / selective schedule ☐ Yes, on schedule

If so, were there any reactions? ______________________________

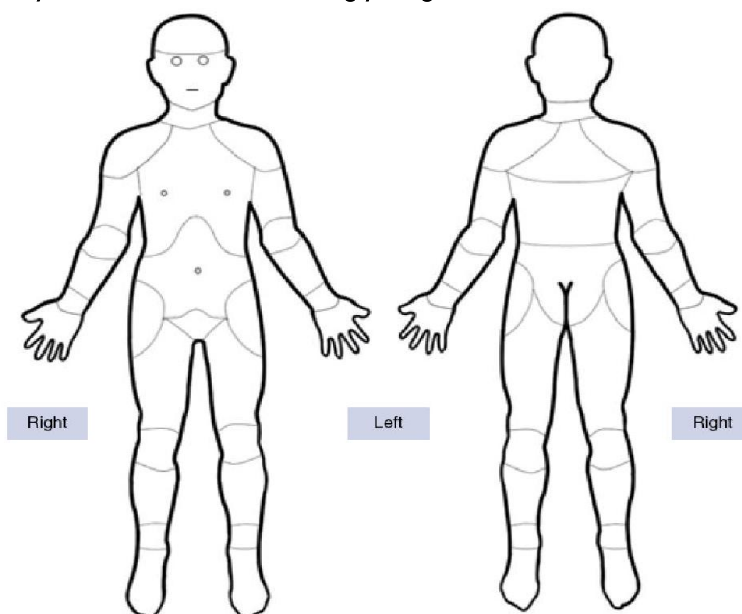
Approximately how many times has your child been prescribed antibiotics and for what conditions? ______________________________

____

Circle your current pain level:



Imagine this picture is your body. Color the area that is hurting you right now:



AUTHORIZATION TO TREAT A MINOR

I understand that I am directly and fully responsible to Triad Health Center for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to select and authorize this care should change in any way, I will immediately notify this office.

______________________ ______________________ ______________________
Parent / Legal Guardian's Printed Name | Parent / Legal Guardian Signature | Date

______________________ ______________________
Doctor's Signature | Date