TRIAD HEALTH CENTER – PEDIATRIC HISTORY FORM – CHIROPRACTIC PROGRAM

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** Heart Trouble	☐ **Y** | ☐ **N** Colic
☐ **Y** | ☐ **N** Orthopedic Problems	☐ **Y** | ☐ **N** Joint Problems	☐ **Y** | ☐ **N** Broken Bones
☐ **Y** | ☐ **N** Digestive Problems	☐ **Y** | ☐ **N** Constipation	☐ **Y** | ☐ **N** Sleep Problems
☐ **Y** | ☐ **N** Behavioral Problems	☐ **Y** | ☐ **N** Growing Pains	☐ **Y** | ☐ **N** Night Terrors
☐ **Y** | ☐ **N** Dizziness	☐ **Y** | ☐ **N** Earaches	☐ **Y** | ☐ **N** Torticollis
☐ **Y** | ☐ **N** Neck Problems	☐ **Y** | ☐ **N** Backaches	☐ **Y** | ☐ **N** Learning Difficulties
☐ **Y** | ☐ **N** Poor Appetite	☐ **Y** | ☐ **N** Diarrhea	☐ **Y** | ☐ **N** Ear Infections
☐ **Y** | ☐ **N** ADD/ADHD	☐ **Y** | ☐ **N** Sinus Trouble	☐ **Y** | ☐ **N** PDD / Autism
☐ **Y** | ☐ **N** Fainting	☐ **Y** | ☐ **N** Poor Posture	☐ **Y** | ☐ **N** Acid Reflux
☐ **Y** | ☐ **N** Arm Problems	☐ **Y** | ☐ **N** Hypertension	☐ **Y** | ☐ **N** Hip Dysplasia
☐ **Y** | ☐ **N** Stomach Aches	☐ **Y** | ☐ **N** Asthma	☐ **Y** | ☐ **N** Tonsillitis
☐ **Y** | ☐ **N** Ruptures/Hernia	☐ **Y** | ☐ **N** Scoliosis	☐ **Y** | ☐ **N** Frequent Fever
☐ **Y** | ☐ **N** Seizures/Convulsions	☐ **Y** | ☐ **N** Anemia	☐ **Y** | ☐ **N** Seasonal Allergies
☐ **Y** | ☐ **N** Leg Problems	☐ **Y** | ☐ **N** Colds/Flu	☐ **Y** | ☐ **N** Allergies to:
☐ **Y** | ☐ **N** Reflux	☐ **Y** | ☐ **N** Walking Trouble	
☐ **Y** | ☐ **N** Muscle Pain	☐ **Y** | ☐ **N** Bed Wetting	Other:

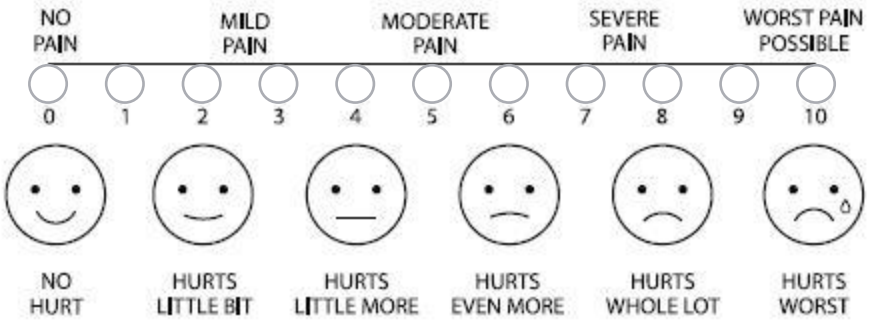
Your child sleeps: ☐ hours per night ☐ hours per day/naps *Sleep quality:* ☐ Good ☐ Fair ☐ Poor

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

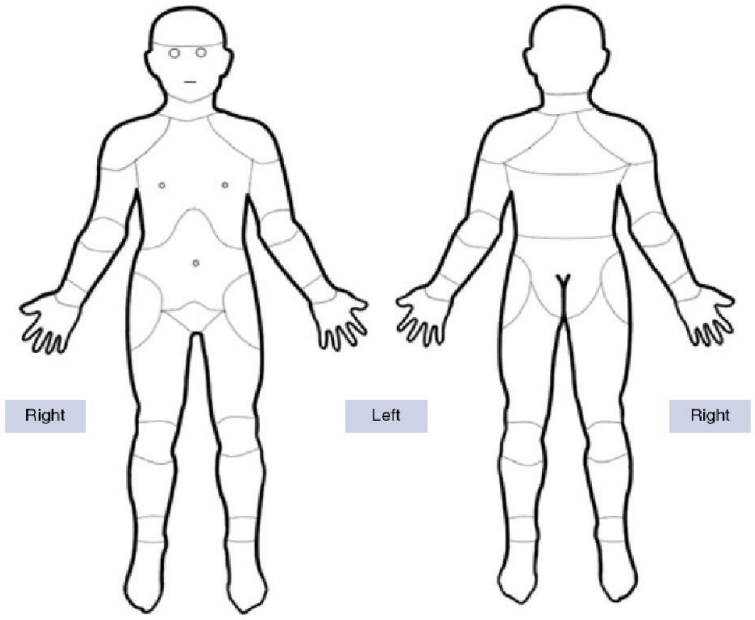
If so, were there any reactions? _____

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

Mark 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 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