Pediatric History Form (Birth to 10 years old)

First Name _____ MI ____ Last Name _____

Home Address _____ City/State/Zip _____

Home Phone _____ Mobile Phone _____

Email Address _____

Date of Birth _____/_____/_____ Social Security Number _____/_____/_____

Height _____ Weight _____ Sex: M F Shoe Size _____

Emergency Contact Name and Phone Number _____

Have you ever been to a Chiropractor before? Yes No
If so, who? _____

CURRENT COMPLAINTS

Is there a musculoskeletal complaint? Yes ___ No ___ **If no, please skip to next page**
Are you concerned about neurodevelopmental disorder (eg. SPD) Yes ___ No ___
Is this complaint due to a car accident? Yes ___ No ___
If yes, please ask for additional intake paperwork.

Complaint #1 _____

Please describe the **location, intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequently is this experienced? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect sleep? Yes ___ No ___ How? _____
Does this condition affect appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Does this condition interfere with daily activities? Yes ___ No ___
Has this condition been experienced at a prior time in life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

MEDICAL HISTORY

Please list conditions you have been treated for in the last 10 years:

Please list all surgeries and operations:

Please list all current medications/dosages:

Please list all nutritional supplementation (please also include vitamins, minerals, and herbs):

A. Maternal Health

Y__ N__ Is this your biological child?

(If no, please answer numbers 2-7 for the biological mother if you have the information, otherwise go on to Section B)

Y__ N__ History of miscarriages.

If yes, how many? _____

Y__ N__ Prescription Drugs During Pregnancy.

If yes, which ones:_____

Y__ N__ Were you on SSRI's? (for depression)

B. The Pregnancy

Any problems with the pregnancy? Y__ N__

If yes, please describe:_____

Y__ N__ Any infections or antibiotics?

Y__ N__ Hospitalized during the pregnancy?

Y__ N__ Use of infertility drugs?

Y__ N__ In-vitro fertilization?

The Birth

Type of Birth: __Vaginal __C-Section* __VBAC

Y__ N__ Premature?

If yes, how many weeks early? _____

Y__ N__ Were you given pitocin?

APGAR Scores ___/___ Or do you remember if they were good or poor? _____

Birth weight: _____

Adverse Events?:_____

_____

_____

Y__ N__ Did the baby receive any antibiotics at the hospital?

Y__ N__ Did the baby receive the Hepatitis B vaccine while in the hospital?

Infancy/Toddler Years - Birth to 2 years of age

Y__ N__ Breastfed?

For how long? _____

Did your child prefer one breast over the other? Y__ N__

If yes, which side? *(circle one)* Right Left

Y__ N__ Bottle-fed?

Y__ N__ Difficulty latching on?

Y__ N__ Difficulty swallowing?

Y__ N__ Excessive drooling?

Y__ N__ Poor head control - “Floppy baby”? (Low muscle tone)

Y__ N__ Colic reflux?

Y__ N__ Ear Infections?

If yes, how many? ___ Were antibiotics given? Y__ N__

Y__ N__ Tubes in ears? Date: _____

Y__ N__ History of thrush? (White overgrowth in mouth)

If yes, how many times? ___

Y__ N__ History of strep?

If yes, how many times? ___ Antibiotics? Y__ N__

Y__ N__ Sinus infections?

If yes, how many times? ___ Antibiotics? Y__ N__

Y__ N__ Seizures?

Y__ N__ Any vaccine reactions?

Describe: _____

Y__ N__ Any rashes or lumps/bumps at injection sites?

Y__ N__ Any asthma/allergies/sensitivities?

Describe: _____

Y__ N__ Any body rashes?

Location: _____

How often? _____

Describe his/her sleep habits as an infant and as a toddler:

_____

_____

Texture of feces (poop):

__ hard "rabbit pellets"

__ enormous rock hard bowel movements

__ formed, hard

__ formed, soft (normal)

__ "mashed potatoes"

__ diarrhea

__ diarrhea and constipation

How often were the bowel movements? _____

Y__ N__ Was he/she very gassy?

Y__ N__ Caught a lot of colds as an infant?

List any therapies your child has now or in the past:

___ Speech	___ Physical Therapy	___Vision Therapy
___ Occupational	___ Social Skills	___ ABA
___Sensory Integration	___ Counseling	___Light Therapy
___ Anger Management	___Music Therapy	___Listening therapy
___Relationship Development Intervention		__Other: _____

Which therapies help the most? _____

CDC's Developmental Health Watch (by 12 months) - *Circle all that apply*

- Does not crawl
- Drags one side of body while crawling (for over one month)
- Cannot stand when supported
- Does not search for objects that are hidden while he or she watches
- Says no single words ("mama" or "dada")
- Does not learn to use gestures, such as waving or shaking head
- Does not point to objects or pictures
- Experiences a dramatic loss of skills he or she once had.

CDC's Developmental Health Watch (by 24 months) - *Circle all that apply*

- Cannot walk by 18 months
- Fails to develop a mature heel-toe walking pattern after several months of walking, or walks only on his toes
- Does not speak at least 15 words
- Does not use two-word sentences by age 2 By 15 months, does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Does not imitate actions or words by the end of this period
- Does not follow simple instructions by age 2
- Cannot push a wheeled toy by age 2
- Experiences a dramatic loss of skills he or she once had

Older Childhood

Y__ N__ Does your child have food allergies?

If yes, explain:_____

Y__ N__ Your child has asthma

Y__ N__ Your child uses an inhaler

Y__ N__ Eczema, rashes, hives (*Circle any that apply*)

Y__ N__ Hyperactivity

Diagnosis of ADD or ADHD? ____

Y__ N__ Depression

Y__ N__ Anxiety

Y__ N__ Difficulty sleeping or staying asleep

Y__ N__ Child is gluten free

Y__ N__ Child is lactose free

Parent Questions or Comments for Doctor:

_____
_____
_____
_____

Which **ONE** of the following do you **MOST** take into consideration when making decisions about your healthcare and the providers you choose?

_____ Cost _____ Time _____ Results _____ Integrity

By signing below I authorize Precision Chiropractic ATX and its staff to use the information provided herein to help make the best decisions for my care. I certify that the information provided is true and accurate to the best of my knowledge. I understand that Precision Chiropractic ATX will work with my insurance company to obtain the highest reimbursement for care, but all costs associated with care are ultimately the responsibility of the patient. All payments are due at the time of service unless otherwise agreed upon in writing by both Precision Chiropractic ATX and the patient.

_____ _____

Patient/Guardian Signature **Date**

How did you find Precision Chiropractic?

___ Referral from current patient Who? _____

___ Referral from healthcare provider Who? _____

___ Fitness professional Who? _____

___ Print advertising Where? _____

___ Google

___ Facebook

___ Yelp

___ Sign/Building

___ Doctor/Staff Presentation

___ Other _____