THE CHIROPRACTIC
wellnessconnection

We are honored that you have chosen us to assist you and your family's health & wellness needs. Please let us know if there is any way we can make you and your family feel more comfortable. We look forward to working with you to build better health for your family.

Pediatric History & Adolescent Form (birth to 16 years)

Patient Name: _____ S.S.# _____

Address: _____City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____ Sex: _____ Weight _____ Height _____

Whom may we thank for referring you to our office? _____

Family Information:

Father's Name: _____ Mother's Name: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Father's Work Phone: _____ Mother's Work Phone: _____

Home Phone: _____ Email: _____

Parent's marital status (please circle): Single Married Divorced Widowed

Name of Insurance Company _____ Policy # _____

At our office we interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may have about yourself or the other members of your family:

Yourself _____
Other Children _____
_____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

Purpose For Contacting Us (√): spinal checkup ___ wellness ___ other ___ please explain:
_____

If Applicable: Other Doctors Seen For This Condition: ___ no ___ yes Doctor's Names and Prior Treatments:

_____

_____

Previous Chiropractor: _____

Date of Last Visit: ___/___/___ Reason: _____

Name of Pediatrician: _____ Date of last visit: ___/___/___ Reason: _____

Mark any of the following conditions your child has is suffering or has suffered from.

Your Child's Health Profile:

Please mark an "**O**" if it is a Past Condition or an "**X**" for Present Condition

___ ear infections	___ scoliosis	___ seizures	___ chronic colds
___ headaches	___ asthma	___ allergies	___ digestive problems
___ ADHD	___ recurrent fevers	___ growing pains	___ colic
___ bedwetting	___ anemia ___	reflux ___	behavioral problem
___ leg problems	___ poor posture	___ broken bones	___ heart trouble
___ stomach aches	___ muscle pain	___ orthopedic problem	___ neck problems
___ joint problems	___constipation/diarrhea	___ poor appetite	___ arm problems
___ back problems	___ walking trouble	___ sinus trouble	___diabetes

Other: _____

Number of doses of Antibiotics your child has taken:

During the past 6 months _____ Total during his/her lifetime _____

Please list any drugs or medications (prescription or over the counter) your child is taking

_____

_____

Please list any vitamins/supplements/herbs/homeopathics/other your child is taking

_____

_____

Vaccination History:

(please check) ___ up to date ___ chose to decline vaccinations

___ still deciding on which vaccinations and at what age to allow administration ___other

Please describe any adverse reactions to vaccinations: _____

_____

I would like more information on the adverse reactions and potential dangers of vaccinations ___ yes ___ no

******Please skip to The Beginning Years if your child is 4 years or above.**

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy: ___ no ___ yes List: _____

Medications during Pregnancy/Delivery ___ no ___ yes List: _____

Cigarette/Alcohol use during Pregnancy ___ no ___ yes

Location of Birth: __ hospital ___ birthing center ___ home

Birth Intervention: ___ forceps ___ vacuum extraction
___ cesarean section, emergency or planned?

Complications during Delivery? ___ no ___ yes List: _____

Genetic Disorders or Disabilities: ___ no ___ yes List: _____

Birth Weight _____ Birth Length _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: ___ no ___ yes How Long: _____

Formula Fed: ___ no ___ yes How Long: _____, Which Formula _____

Does the baby prefer feeding on one side than the other? ___ yes ___ no side preferred _____

Introduced to Solids at: _____ Months, Cow's Milk at _____ Month

Food/Juice Allergies, Sensitivities, or Intolerances: ___ no ___ yes List: _____
_____

Developmental History:

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

_____ Respond to Sound _____ Cross Crawl _____ Sit Up

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Hold Head Up _____ Walk Alone

The Beginning Years

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please (√) the appropriate answer to following questions with the best of your ability.

Did your child have a traumatic birth? ___ yes ___ no ___ unsure
(Cesarean, forceps, long labor)

Haa your child had any serious falls? ___ yes ___ no ___ unsure
(includes falls from crib/bunk bed/changing station/tree)

Did/Does your child play youth sports? ___ yes ___ no ___ unsure

Has your child been involved in any car accidents? ___ yes ___ no ___ unsure

Has your child been under regular chiropractic care? ___ yes ___ no ___ unsure

On average, how many hours of sleep does your child get per night? _____

Bio-Chemical : (Ages 3 and above)
(Questions based on days/week)

	Never (0 days)	Rarely (1-2days)	Occasionally (3-5 days)	Always (6-7 days)
Does your child drink 2-8 glasses of water?	[ ]	[ ]	[ ]	[ ]
Does you child take a Fish oil supplement?	[ ]	[ ]	[ ]	[ ]
Does your child eat 4-8 servings of fruits & vegetables (raw or steamed)?	[ ]	[ ]	[ ]	[ ]

	Always (6-7 days)	Occasionally (3-5 days)	Rarely (1-2 days)	Never (0 days)
Does your child use Splenda, or other artificial sweetners?	[ ]	[ ]	[ ]	[ ]
Does your child eat Fast Foods?	[ ]	[ ]	[ ]	[ ]
Does your child take medication?	[ ]	[ ]	[ ]	[ ]
Does your child eat processed, Packaged or pre-made foods?	[ ]	[ ]	[ ]	[ ]
Does your child eat sugary snacks, candies or cereals?	[ ]	[ ]	[ ]	[ ]
Does your child drink soda?	[ ]	[ ]	[ ]	[ ]
Does your child eat white bread and or pastas?	[ ]	[ ]	[ ]	[ ]

Bio-Physical (Ages 5 and above)

(Questions based on days /week)	Always (6-7 days)	Occasionally (3-5 days)	Rarely (1-2 days)	Never (0 days)
Do you feel your child's book bag is too heavy for them?	[ ]	[ ]	[ ]	[ ]
Does your child : 1.) watch T.V., 2.) play video games and/or 3.) play on computer for more than 2.5 hours/day? (Combined)	[ ]	[ ]	[ ]	[ ]

	Never (0 days)	Rarely (1-2 days)	Occasionally (3-5 days)	Always (6-7 days)
Does your child get at least 1 hour Of physical activity daily?	[ ]	[ ]	[ ]	[ ]

Lifestyle (Age 5 and above)

(Questions based on days/week)

	Always (6-7 days)	Occasionally (3-5 days)	Rarely (1-2 days)	Never (0 days)
Does your child have difficulty concentrating?	[ ]	[ ]	[ ]	[ ]
Does your child complain of feeling overwhelmed or frustrated?	[ ]	[ ]	[ ]	[ ]
Does your child get angry easily?	[ ]	[ ]	[ ]	[ ]
Is your child confident in social settings?	[ ]	[ ]	[ ]	[ ]

Staff Use : Total Score _____

WE ARE HERE TO SERVE YOU.

WE ENCOUGAGE YOU TO ASK QUESTIONS.

YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR FAMILY'S RESULTS.

AUTORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____ Date: _____

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