HEALTHY LIVING
Family Chiropractic

Patient# __________

Today's Date ____/____/______

PEDIATRIC HEALTH HISTORY
(Infant to 2 years)

We are excited that you have chosen Healthy Living Family Chiropractic to assist in the health and wellness needs of you and your family! Let us know if there is anything we can do to make you more comfortable.
Please fill out this form as completely as possible so we can provide the best possible care for your family.

PERSONAL INFORMATION

Child's Name____________________________________ What he/she prefers to be called_____________________________

Home Address_____________________________________ City_________________________ State______ Zip____________

Age_____ Date of Birth____/____/______ Sex___ Height___________ Weight__________ SS#_________________________

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

FAMILY INFORMATION: *Primary Contact (for appointment reminders, etc.):* ◻ *Father* ◻ *Mother*

Father's Name______________________________________ Mother's Name____

Father's Cell Phone (_____) ________________ Mother's Cell Phone (_____) ________________

Father's Work Phone (_____) ________________ Mother's Work Phone (_____) ________________

Home Phone (_____) ________________ E-mail ____

Parent's Marital Status: ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed ◻ Living Together

Preferred method of being reminded of appointments: ◻ *Phone Call* ◻ *Text Message (no charge to you)* ◻ *E-mail*

If text message reminders, we also need your cell phone carrier in order to send text: _______________________

REASONS FOR SEEKING CHIROPRACTIC CARE

At Healthy Living Family Chiropractic, we focus on your child's ability to be healthy.
Our goals are to first address the issues that brought your child to this office and second, to offer your child the opportunity of improved health, wellness and quality of life in the future.

Please briefly describe the main concern that you would like Healthy Living Family Chiropractic to address for your child.

____

____

HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for ***this condition***: ◻ Chiropractor ◻ Medical Doctor ◻ Other – please list____________________

Name__________________________________ City______________________________ Date___________________

X-rays taken ◻ No ◻ Yes ____________________ Special tests done ◻ No ◻ Yes ____________________

Diagnosis______________________________ What was done____

Has your child ever had ***chiropractic care***? ◻ No ◻ Yes Name of D.C.____________________________________

How long under care? ◻ ______days ◻ ______weeks ◻ ______months ◻ ______years

Date of last visit__________________ Why was care stopped? ____

Are you satisfied with the care your child received there? ◻ No ◻ Yes

Has your child consulted or does he/she ***regularly consult*** any of the following providers? (check all that apply)

□ Medical Physician □ Naturopath □ Acupuncturist □ Homeopath

□ Massage Therapist □ Psychotherapist □ Optometrist □ Dentist

Name of Pediatrician ____ City ________________________________

Date of last visit ____/____/______ Reason ____

Are you satisfied with the care your child has received there? □ Yes □ No

YOUR CHILD'S HEALTH PROFILE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to and ***how they may relate to his/her present spinal, nerve and health status.***

GENERAL HISTORY

Please mark all symptoms your child has ever had, even if they do not seem related to the current problem.

□ Ear infections □ Seizures □ Chronic Colds □ Asthma

□ Allergies □ Digestive problems □ ADHD □ Recurrent fevers

□ Colic □ Anemia □ Reflux □ Behavioral problems

□ Leg problems □ Diabetes □ Heart trouble □ Orthopedic problem

□ Neck problems □ Joint problems □ Constipation □ Diarrhea

□ Poor appetite □ Arm problems □ Back problems □ Trouble walking

□ Sinus problems □ Passes a lot of intestinal gas □ Other __________________________

Please list any other ***serious medical condition(s)*** your child currently has or has ever had:

____

____

PRENATAL HISTORY

Name of Obstetrician/Midwife ____

Social history while pregnant:

Did you: □ Exercise regularly □ Eat a balanced diet □ Obtain sufficient rest

Did you smoke? □ No □ Yes – How many packs per day __________

Did you drink alcohol? □ No □ Yes – How many drinks per day __________

Did you drink caffeine? □ No □ Yes – In what form (coffee, tea, etc.) ___________________________

Medications/Supplements while pregnant – please list ____

____

Were there complications during pregnancy? □ No □ Yes Please explain: ___________________________________

____

Labor and Delivery:

Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention: □ Forceps □ Vacuum extraction □ Cesarean section (Emergency or Planned)

Were there complications during delivery? □ No □ Yes - Please explain: ________________________________

____

Birth Weight (pounds) __________ Birth Length (inches) __________

FEEDING HISTORY

Breast Fed: □ No □ Yes – How long? __________months

Formula Fed: □ No □ Yes – How long? __________months Formula Brand: ________________________________

Does baby prefer feeding on one side more than the other? □ No □ Yes – Which side? _____

After a feeding does the baby frequently spit-up? □ No □ Yes

Introduced to solids at _____ months Introduced to cow's milk at _____ months

Food/Drink allergies, sensitivities or intolerances: □ No □ Yes – Please list: ____________________________________

____

PHYSICAL STRESS

Has your child ever suffered from the following ***traumas***?

□ Fall in baby walker □ Fall from bed or couch □ Fall off swing

□ Fall from highchair □ Fall from crib □ Fall down stairs

□ Fall off slide □ Fall off changing table □ Fall off monkey bars

□ Other _____________________________

Has your child ever been in a ***car accident***? □ No □ Yes – please explain ____________________________________

____

Has your child ever had a ***bone fracture or joint dislocation***? □ No □ Yes – please explain ____________________

____

Has your child had any ***other traumas*** not described above? □ No □ Yes – please explain ______________________

____

Does your child ***sleep through the night***? □ No □ Yes – please explain: ____________________________________

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

CHEMICAL STRESS

Vaccination history: □ up to date □ chose to decline vaccinations □ revised vaccination schedule

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

□ I would like more information on the adverse reactions and potential dangers of vaccinations.

Please describe any adverse reactions to any vaccinations: ____

Number of ***doses of antibiotics*** your child has taken: During the past 6 months _____ Total during lifetime _____

Please list any ***drugs or medications*** (prescription or over-the-counter) your child is taking and the reason why.

____

Please list any ***vitamins, supplements, herbs, homeopathics, etc.*** that your child is taking and the reason why.

____

Do you have any concerns with your ***child's diet***? ◻ No ◻ Yes – please explain: _______________

____

FAMILY HISTORY

Mother: ◻ In good health ◻ Heart ◻ Diabetes ◻ High Blood Pressure ◻ Respiratory Problems
◻ Kidney ◻ Stroke ◻ Cancer ___________ ◻ Other ___________

Father: ◻ In good health ◻ Heart ◻ Diabetes ◻ High Blood Pressure ◻ Respiratory Problems
◻ Kidney ◻ Stroke ◻ Cancer ___________ ◻ Other ___________

Siblings: ◻ In good health ◻ Heart ◻ Diabetes ◻ High Blood Pressure ◻ Respiratory Problems
◻ Kidney ◻ Stroke ◻ Cancer ___________ ◻ Other ___________

ADDITIONAL QUESTIONS

If there is a need for ***dietary changes or nutrients***, would you like to be informed? ◻ Yes ◻ No

If there is a need for ***specific exercises***, would you like to be informed? ◻ Yes ◻ No

Is there any ***specific health topic*** you would like more information on? _______________

EXPECTATIONS

I would like my child to have the following benefits from ***Chiropractic Care***: (check all that apply)

◻ Relief of a symptom or problem

◻ Relief and Prevention of a symptom or problem

◻ Healthier spine and nerve system

◻ Best possible health on all levels

PLEASE READ AND SIGN BELOW

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give the doctors of Healthy Living Family Chiropractic permission to administer care to my son/daughter as they deem necessary. The initial visit includes a professional and complete health history/consultation and chiropractic examination/evaluation.

Parent Name_______________ Signature _______________ Date ____/____/______

Thank you for choosing our practice! We look forward to helping your family.

DEVELOPMENTAL ACCOMPLISHMENTS

Please check which skills your child can perform in each section.

GROSS MOTOR SKILLS

- □ holds head up from the table momentarily
- □ pushes up with hands and forearms
- □ can be pulled up into sitting position by hands
- □ sits unsupported in the upright position
- □ rolls from back to belly
- □ crawls
- □ stand holding onto something
- □ walks with someone holding onto one hand
- □ walks unassisted
- □ runs
- □ negotiates stairs placing 2 feet on each step
- □ negotiates stairs placing 1 foot on each step
- □ hops on 1 foot

FINE MOTOR SKILLS

- □ grabs your finger when put in palm
- □ holds and shakes a rattle placed in the hand
- □ grabs objects by him/her self
- □ moves an object from one hand to the other
- □ self-feeding – can hold and eat a cracker
- □ checks objects by placing them in the mouth
- □ picks up object with thumb and pointer finger
- □ turns 2 to 3 pages of a book at the same time
- □ turns 1 page of a book at a time
- □ builds a tower containing at least 5 blocks
- □ builds a tower containing at least 10 blocks

SOCIAL SKILLS

- □ smiles
- □ reaches for familiar objects
- □ plays with hands
- □ plays with feet
- □ clearly shows joy and pleasure
- □ feeds self with fingers
- □ plays peek-a-boo
- □ understands yes and no

COMMUNICATION SKILLS

- □ makes cooing sounds
- □ laughs
- □ uses 1 syllable words such as "ma"
- □ uses 2 syllable words such as "mama"
- □ uses 2-3 word sentences

ADAPTIVE SKILLS

- □ drinks from a cup unassisted
- □ holds own bottle
- □ feeds self with spoon and fork
- □ able to identify and match same colors
- □ copies a circle
- □ copies a cross

Parent Name________________________________ Signature ______________________________ Date ____/____/______