HEALTHY LIVING
Family Chiropractic

Patient# _____

Today's Date ____/____/_____

PEDIATRIC HEALTH HISTORY
(3 to 7 years)

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.

_____

_____

Are these concerns affecting your child's quality of life? (check all that apply)

□ School □ Exercise/Sports □ Eating □ Sleep □ Hobby □ Other _____

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 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	□ Scoliosis	□ Seizures	□ Chronic Colds
□ Headaches	□ Asthma	□ Allergies	□ Digestive problems
□ ADD/ADHD	□ Recurrent fevers	□ Growing pains	□ Colic
□ Bedwetting	□ Anemia	□ Reflux	□ Behavioral problems
□ Leg problems	□ Poor posture	□ Diabetes	□ Heart trouble
□ Stomach aches	□ Muscle pain	□ Orthopedic problem	□ Neck problems
□ Joint problems	□ Constipation	□ Diarrhea	□ Poor appetite
□ Arm problems	□ Back problems	□ Trouble walking	□ Sinus problems

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: _____

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 skates/skateboard
□ Fall off swing	□ Fall from crib	□ Fall off bicycle
□ Fall from highchair	□ Fall off slide	□ Fall down stairs
□ Fall off changing table	□ Fall off monkey bars	□ Other _____

Has your child ever been involved in ***organized sports*** (i.e. football, soccer, baseball, basketball, gymnastics, cheerleading, martial arts, etc.)? □ No □ Yes – please list_____

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 _____

_____

Do you feel your child's ***book bag*** is too heavy for him/her? □ No □ Yes

How many hours per day does your child: □ Watch TV _____ □ Use a computer _____ □ Play video games _____

Does your child ***sleep through the night***? □ No □ Yes How many ***hours of sleep*** 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: _____

EMOTIONAL STRESS

Does your child have ***difficulty concentrating***? □ No □ Yes – please explain: _____

_____

Does your child complain of feeling ***overwhelmed or frustrated***? □ No □ Yes – please explain: _____

_____

Does your child get ***angry easily***? □ 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

If there is a need for support in the ***emotional/stress area of health***, 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 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.