BROWN FAMILY CHIROPRACTIC
A Part of Your Lifestyle

Pediatric Health History

Date _____

Child's Name _____
Date of Birth _____
Child's Height _____
Child's Weight _____

Sex
❑ Male ❑ Female

Home Phone _____ Cell Phone _____

Address _____

Doctor's Name _____

Doctor's Address _____

Name of Previous Doctor of Chiropractic _____
Date of Last Visit _____

Names of Parents or Guardians _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature _____

What are your chief concerns, if any, with your child's health?

_____

_____

What are your goals for care?

_____

_____

List any other care your child has undergone with regards to this complaint including medication:

_____

_____

Date of onset: (mm/dd/yyyy) _____	Onset was: (circle one) Sudden Gradual Associated with an event
Duration of problem or episode: (circle one) Minutes Hours Days Months Years	Pattern of problem: (circle one) Constant Intermittent Occasional Cyclical

Initiating Factors _____

Aggravating Factors _____

Relieving Factors _____

How does the problem affect your child's body function and daily activities?

_____

Prior occurrence or episodes? _____

Other health concerns? _____

_____

CHILD'S NAME

HISTORY OF BIRTH

Hospital / Birthing Center ❑ Home ❑ Medical ❑ Midwife Duration of Gestation _____ weeks

Was the birth assisted? ❑ Yes ❑ No If yes, how? ❑ Forceps ❑ Vacuum Extraction ❑ C-Section ❑ Induced

Were medications given to mother at birth? ❑ Yes ❑ No If yes, what? _____

Duration of Birth _____ Was the birth normal? ❑ Yes ❑ No
If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Height _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ❑ Yes ❑ No
If no, explain _____

At what age did the child: Respond to sound?_____ Follow an object?_____ Hold up head? _____
Vocalize?_____ Sit alone?_____Teethe?_____Crawl?_____Walk? _____
Do his/her sleeping patterns seem normal? ❑ Yes ❑ No Explain _____

Do the child's siblings have any health problems? ❑ Yes ❑ No If yes, describe _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

CHEMICAL STRESSORS

During pregnancy, did mother: Smoke ❑ Yes ❑ No Drink alcohol? ❑ Yes ❑ No Take vitamins? ❑ yes ❑ No
Take drugs? ❑ Yes ❑ No If yes, what?_____Become ill? If so, how ❑ Yes ❑ No _____
Receive ultrasounds? ❑ Yes ❑ No How many?____Receive invasive procedures (amniocentesis)? ❑ Yes ❑ No

Was your child breast fed? ❑ Yes ❑ No If yes, for how long?_____weeks months years
At what age was: First formula introduced?_____ Brand?_____Cow's milk? _____yrs Solid food? _____mnth

Did your child receive vaccinations? ❑ Yes ❑ No If yes, which ones? _____
Did your child react to them? ❑ Yes ❑ No Explain: _____
Has your child had antibiotics? ❑ Yes ❑ No If yes, how many courses so far & why? _____
Any pets in the home? ❑ Yes ❑ No Any smokers at home? ❑ Yes ❑ No If yes, how much? _____

PSYCHOLOGICAL STRESSORS

Does your child have any behavior problems? ❑ Yes ❑ No Explain: _____
Does your child have difficulties sleeping (night terrors, sleepwalking, etc.)? ❑ Yes ❑ No
If yes, explain _____

TRAUMATIC STRESSORS

Any evidence of trauma during birth? ❑ Bruises ❑ Odd shaped head ❑ Stuck in birth canal ❑ Fast/long birth
❑ Respiratory depression ❑ Cord around neck ❑ Other: _____
Any falls during pregnancy? ❑ Yes ❑ No Has the child had any major falls since birth? ❑ Yes ❑ No
If yes, did the child require stitches or cause a fracture? Describe: _____
Any hospitalizations? ❑ Yes ❑ No Please explain: _____

Does your child play sports? ❑ Yes ❑ No Number of hours per week? _____Age child began _____yrs

Weight of school backpack? _____lbs Approximate hours spent at play per week _____hrs