Trinity Chiropractic Wellness

Live Well. Move Well. Be Well.

Pediatric History Form

Date: ______________________

Name: ____ DOB: ______________________

Mother's Name ______________________ Father's Name________________________

Mother's Address___________________________ City ___________________________

State _____ Zip __________Telephone # _________________ Cell _________________

Father's Address (if different) ______________________ City _____________________

State _____ Zip __________Telephone # _________________ Cell ________________

Referred by ____

Present MD and Address ____

AUTHORIZATION FOR CARE OF A MINOR

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

____

Parent/Guardian Signature Date

____

Witness Signature Date

CHIEF HEALTH CONCERNS

____

____

____

____

List care undergone for this/these complaint(s), including medications:

____

____

____

Date of Onset __________ Onset was (check one): Sudden _____Gradual ______

Duration of problem (episode) _________ ▫ minutes ▫hours ▫days ▫months ▫years

Pattern of problem: ▫ Constant ▫ Intermittent ▫ Occasional ▫ Cyclical

Any prior occurrences or episodes? ____________________________________

Prior treatment and results: ____

Present Length/Height ______________ Weight _______________

HISTORY OF BIRTH

Hospital/Birthing Center: ▫ Home ▫ Medical ▫ Midwife

Duration of Gestation: ______ Weeks

Assisted With: ▫ Forceps, ▫ Vacuum Extraction ▫ C-Section, ▫ Induced Labor

Duration of labor: ________ Duration of birth: ____________

Complications at birth: ____

____

____

Medications delivered to mother at birth? ____________________

Was delivery normal? ▫ Yes ▫ No

APGAR at Birth _________ After 5 Minutes ______

Birth Weight __________ Birth Length __________

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ▫ Yes ▫ No

Explain____

Has child reached all milestones on time? If no, which were delayed?

____

Do sleeping patterns seem normal to you? ▫ Yes ▫ No

Family Health Problems:

Mother's side____

Father's side ____

Siblings ____

CHEMICAL/FEEDING HISTORY

Was baby breast-fed? ▫ No ▫ Yes

How Long? ______________________ Formula introduced at age __________________

Type of formula used: ____________ Cow's milk introduces at age _________________

Began solid foods at age ______Food/Juice intolerance ▫ No ▫ Yes Type:____________

During pregnancy did mother:

Smoke? ▫ Yes ▫ No   Drink alcohol? ▫ Yes ▫ No

Any illness of the mother during pregnancy? ____________________________________

Supplements taken during pregnancy? ____

Any drugs taken during pregnancy? ____

Any exposure to ultrasound? ▫ No ▫ Yes

If so, how many,why?____

Any invasive procedures (Amniocentesis, CVS)___________________________________

Any pets at home? ▫ No ▫ Yes

Any smokers in the home? ▫ No ▫ Yes How much? ________________________________

Any vaccinations? ▫ No ▫ Yes

Which ones, and any reactions?____

Any antibiotics? ▫ No ▫ Yes For: ____

Total number of courses of antibiotics to date:___________________________________

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? ▫ No ▫ Yes

Any problems with bonding? ▫ Mother ▫ Father

Any behavioral problems? ▫ No ▫ Yes

Type:____ Onset:__________

Any night terrors, sleepwalking, difficult sleeping? ▫ No ▫ Yes

Specify ____

Age when daycare began? __________

Average number of hours of television per week? ___________________________

Does your child seem normal for their age? ▫ Yes ▫ No

TRAUMATIC STRESSORS

Any traumas during pregnancy (falls, accidents)? ___________________________

____

Any evidence of birth trauma: bruises, odd-shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other?____________

____

Any falls from couches, beds, change tables? _____________________________

Any traumas with bruising, cuts, stitches, fractures?__________________________

Any hospitalizations? ▫ No ▫ Yes

Explain:____

Any surgeries or organs removed? ______________________________________

Sports played and age began:____

Weight of school backpack: _______Approx. hours spent at play per week: __________

Thank you for telling us about your child. Please write any other questions/concerns you have below.

____

____

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