Living Wise Chiropractic

Pediatric history form

Patient (Child) Information:

Name: _____ Date: _____
Address: _____
Sex: Male Female Date of Birth: _____ Height:_____ Weight: _____
Name of Parents/Guardian:_____
Home Phone:_____ Cell Phone: _____
Work Phone: _____Email:_____

Present complaint if any: _____
_____
When did this begin?_____ Was there an accident or injury involved? Y N
Has your child had any past treatment for this complaint? Y N
Describe: _____
Current medications: _____

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain: _____
_____
Medications taken during pregnancy: _____
Cigarettes or alcohol during pregnancy: Y N
Birth Intervention: Forceps Vacuum C-Section Complications during delivery? Y N
Explain: _____ _____
Genetic disorders or disabilities: _____
How many times has your child been prescribed antibiotics in the past 6 months? _____
Total during lifetime:_____ Has your child received vaccinations? Y N

Feeding History:

Breast Fed: Y N How long: _____
Formula Fed: Y N How long: _____
Introduced to: Solids at _____ Months
Cows milk at _____ Months
Food Allergies or Intolerances: Y N
List:_____

Childhood Diseases:

Chicken Pox: Y N Age:_____
Rubella: Y N Age:_____
Rubeola: Y N Age:_____
Mumps: Y N Age:_____
Whooping Cough: Y N Age:_____
Other: _____ Age:_____

Leah Carlson DC, 4959 Olson Memorial Hwy., Golden Valley, MN 55422, 612-874-3980

Developmental History:

During the following times your child's spine is the 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
_____ Respond to Visual Stimuli
_____ Hold Head Up Alone
_____ Sit Up Alone
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N

Explain: _____

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

Has your child ever been involved in a car accident? Y N

Explain:_____

Other traumas not described above? Y N

Explain:_____

Prior surgeries? Y N

Explain:_____

Review of Systems

Please check if your child has had any of the following:

____ Headaches
____ Scoliosis
____ Torticollis
____ Sleep Problems
____ PDD/Autism
____ Colic
____ Hip Dysplasia
____ Postural Imbalances
____ Tonsillitis
____ Ear Infections
____ Digestive Problems
____ ADD/ADHD
____Learning Difficulties
____ Allergies
____ Growing Pains
____ Asthma
____ Seizures
____ Bedwetting
____ Frequent Fever
____ Acid Reflux

How would you rate your child's diet? ____ Well Balanced ____ Average ____High sugar/processed foods Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps:_____ hours per night

_____hours per day/naps Sleep Quality: ____Good ____Fair ____Poor

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Authorization to Treat a Minor I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Leah Carlson to perform any examination and chiropractic diagnosis or treatment which is deemed necessary. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: _____ Signature: _____

Print name Parent/legal guardian

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