VICTORIA FAMILY CHIROPRACTIC

Pediatric Health History

Date _______________

PATIENT HISTORY (children 10 years and younger)

Name ____ Email_________________________________

Address _____________________________________ City/Prov _________________Postal ___________________

Birthdate (M/D/Y) ______________________________Sex □ M □ F Care Card # ____________________________

Height/Weight: _________________________________

Mothers Name_________________________________ Fathers Name_____________________________________

Mothers Phone_________________________________ Fathers Phone___________________________________

Mothers Email__________________________________ Fathers Email__________________________________

HOW CAN WE HELP YOUR CHILD?

□ Wellness Checkup □ Other ____

____

If your child is already experiencing a symptom, please describe it:

____

____

____

Past Chiropractic care? If yes, for what and when? ____

Has your child been treated on an emergency basis? □ Yes □ No

Please describe:____

____

MOTHER'S PREGNANCY HISTORY OF THIS CHILD

□ Back/Other pain □ Gestational Diabetes □ Pre/Eclampsia

□ Strep B □ Nausea/Vomiting □ Pre-Term

□ Fatigue □ Swelling

□ Other (please describe____

____

BIRTH HISTORY

□ Hospital □ Birth Center □ Home

□ Normal Vaginal □ Breech □ Cesarean

□ Scheduled/Induced □ Epidural

Problems duringlabor/delivery?____

____

□ Antibiotics □ Congenital Anomalies □ Failure to thrive

□ Jaundice □ Meconium □ Respiratory Distress

□ Extended Hospitalization □ Other____

GROWTH AND DEVELOPEMENT

Infant feeding □ Breast □ Bottle □ Formula

Number of hours of sleep each night_________________ Quality of sleep____________________________________

At what age did the child:

Respond to sound______________ Crawl__________________ Hold head up________________________________

Stand________________________ Sit unsupported _________________Walk unsupported_____________________

CHILDHOOD DESEASES & ILLNESSES

Has your child had (check all that apply)?

□ Chicken Pox
□ Measles
□ Rubeola
□ Mumps
□ Rubella
□ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?

□ Allergies
□ Anemia
□ Arm Problems
□ Asthma
□ Autism/Learning Disabilities
□ Back
□ Bed Wetting
□ Behavioral Problems
□ Broken Bones
□ Chronic Ear Aches
□ Colds/Flu
□ Colic
□ Convulsive Seizures
□ Delayed Speech
□ Diabetes
□ Digestive Issues (constipation/diarrhea)
□ Dizziness
□ Fainting
□ Headache
□ Heart Trouble
□ Hyperactivity
□ Hypertension
□ Juvenile Rheumatoid Arthritis
□ Joint Problems
□ Leg Problems
□ Neck Problems
□ Neuritis
□ Orthopedic Problems
□ Paralysis
□ Poor Appetite
□ Ruptures/Hernias
□ Sinus Trouble
□ Tuberculosis
□ Walking Problems

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

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MEDICATIONS (list)

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SURGERIES (list)

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FAMILY HISTORY (list)

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