

PEDIATRIC HEALTH HISTORY (3-13)

Child's Name: _____ Date: _____

Birthdate: _____ Child's Age: _____ Sex: Male Female

Parent or Guardian's Name: _____

Address: _____ City / Town: _____

Postal Code: _____ Home Phone: _____ Other Number: _____

Health card number: _____

Family Doctor's Name: _____ Clinic: _____

Who may we thank for referring you? _____

Has your child ever received chiropractic care: Yes No Date of last visit: _____

If yes, who was your child's previous Doctor of Chiropractic: _____

The reason for last visit: _____

PRESENT HEALTH CONCERNS (Please tell us about your reason for coming to our clinic)

Primary Concern: _____

Secondary Concern: _____

When did the problem begin? _____

Is this problem: frequent constant intermittent improving worsening

What makes this worse? _____

What makes this better? _____

Is the problem worse during certain times of the day? Yes No

If yes, when? _____

Does this interfere with sleep? Yes No Does this interfere with appetite / eating? Yes No

Does this interfere with daily routine? Yes No

Has another health care professional been seen for this condition? Yes No

Was there any treatment? Yes No Result of this treatment? _____

Recent tests (list date): Blood work _____ Urine _____ X-Rays _____

Other _____

Does your child take any medications? What are the dosages? For what conditions? _____

Please indicate if any of the following are currently being experienced or have been experienced in the last year:

- headaches
- dizziness
- irritability
- fatigue
- depression
- fainting
- loss of concentration
- poor coordination
- loss of memory
- light sensitivity
- loss of balance
- vision changes
- loss of smell
- loss of taste
- difficulty breathing
- shortness of breath
- allergies
- bronchitis
- pneumonia
- fevers
- ears buzzing
- ear pain/infections
- asthma
- sinus congestion
- sore throats
- frequent colds
- reduced mobility
- cold sweats
- constipation
- diarrhea
- bloating/gas
- urinary problems
- weight loss
- weight gain
- food allergies/sensitivities
- heartburn
- dental problems
- muscle cramps
- upper back pain
- neck pain
- low back pain
- radiating pain
- sleeping problems
- numbness in leg(s)
- body stiffness
- body awkwardness

What sports and activities does your child participate in? How many hours per week?

Is there any history of sports or activity related injuries? _____

Describe: _____

Has your child ever been involved in any motor vehicle accidents? If yes, when? _____

If yes, what treatment was sought _____

Does your child have any history of surgeries, hospitalizations, fractures, concussions, etc.? _____

Is a school backpack used? Yes No Is it: Heavy Medium Light

Does your child take any vitamins or supplements? _____

Does your child have any allergies or sensitivities? _____

Does your child have any learning challenges? Yes No

If yes, what type: _____

Does your child have: Night terrors Difficult sleeping Hyperactivity Restlessness

Other: _____

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers Family: _____

Fathers Family: _____

Siblings: _____

Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully!

In order for the health professional as indicated below to make a determination on the suitability of my child's guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I have had the opportunity to discuss with the attending Doctor of Chiropractic about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Patient's Name: _____ Parent or Guardians name: _____

Date: _____ Signature (of guardian or parent): _____

Signature of Attending Chiropractor: _____