

Chiropractic Care Center ~ Franklin

9735 W. St. Martins Rd. (Hwy 100 & Loomis Rd.) Franklin, WI 53132 ~ 414-525-9895

Pediatric Health History Record (Age 0 – 9 years old)

Child's Name _____ Gender _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Date of Birth _____ Age _____
Weight _____ Height _____ Referred by _____
Siblings (Names & Ages) _____
Race/Ethnicity (Please circle): Caucasian African American Hispanic American Indian/Alaska Native
Asian/Pacific Islander Other _____
Primary language spoken _____ Secondary language spoken _____

Mother's Name _____ SS# _____
Address (if different) _____ City _____ State _____ Zip _____
Cell Phone Number _____ Email address _____
May we contact you by phone call, text and/or email? Please circle: Yes / No

Father's Name _____ SS# _____
Address (if different) _____ City _____ State _____ Zip _____
Cell Phone Number _____ Email address _____
May we contact you by phone call, text and/or email? Please circle: Yes / No

1. FAMILY MEDICAL HISTORY

Please check if any blood relatives to the patient had any of the following illnesses & mark accordingly by noting: **M** (Mother); **F** (Father); **S** (Sibling); **PGM** (Paternal grandmother); **MGM** (Maternal grandmother); **PGF** or **MGF**.

_____ Allergy	_____ High Blood Pressure / Stroke
_____ Asthma	_____ Kidney Disease
_____ Birth Defect _____	_____ Liver Disease
_____ Cancer _____	_____ Mental Illness / Nervous Disorders
_____ Diabetes / Low Blood Sugar	_____ Scoliosis
_____ Eczema / Psoriasis	_____ Seizures / Epilepsy
_____ Heart Trouble	_____ Ulcer
_____ Other (Please explain) _____	

2. PREGNANCY HISTORY

Please check any area that applied to the patient's mother during her pregnancy.

_____ Abnormal Bleeding	_____ Indigestion
_____ Allergic Reactions	_____ Medications
_____ Anemia	_____ Mental Illness
_____ Asthma	_____ Morning Sickness
_____ Attitude – Happy or Depressed	_____ Physical Injury (Fall, Car Accident)
_____ Back Pain or Other Pain	_____ Premature Contractions
_____ Caffeine	_____ Prenatal Classes
_____ Chiropractic Care	_____ Recreational Drugs / Cigarettes / Alcohol
_____ Complications	_____ Seizures
_____ Diabetes	_____ Swelling
_____ Excessive Increase / Decrease in Weight	_____ Thyroid Problems
_____ Heart Problems	_____ Ultrasounds
_____ High / Low Blood Pressure	_____ Vitamins / Minerals
_____ Hospitalizations	_____ Other (Please Explain) _____

3. LABOR & DELIVERY HISTORY

<input type="checkbox"/> Birthing Center	<input type="checkbox"/> Epidural	<input type="checkbox"/> Induced Birth
<input type="checkbox"/> Breastfeed at Birth	<input type="checkbox"/> Fetal Monitor Used	<input type="checkbox"/> Meconium Staining
<input type="checkbox"/> Breech	<input type="checkbox"/> Forceps Used	<input type="checkbox"/> Medication _____
<input type="checkbox"/> Cesarean	<input type="checkbox"/> Greater than 12 hours	<input type="checkbox"/> Midwife
<input type="checkbox"/> Complications	<input type="checkbox"/> Home Birth	<input type="checkbox"/> Premature Delivery
<input type="checkbox"/> Doula	<input type="checkbox"/> Hospital Birth	<input type="checkbox"/> Vacuum Extraction
<input type="checkbox"/> Other (Please Explain) _____		

4. NATAL HISTORY

The duration of the pregnancy was _____ weeks.

The APGAR score at birth was _____.

The APGAR score at 5 Minutes was _____.

The length at birth was _____.

The weight at birth was _____.

Please check any **problems** the patient had **at birth**:

<input type="checkbox"/> Breastfeeding Problems	<input type="checkbox"/> Colic
<input type="checkbox"/> Bottle Feeding Problems	<input type="checkbox"/> Crying
<input type="checkbox"/> Breathing / Cyanotic (Blue)	<input type="checkbox"/> Jaundice (Yellow)
<input type="checkbox"/> Choking	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Other (Please explain) _____	

Please check if any item(s) applied to the patient **at birth**:

<input type="checkbox"/> Artificial Feeding	<input type="checkbox"/> Vitamin K (For Clotting)
<input type="checkbox"/> Birthmarks _____	<input type="checkbox"/> Silver Nitrate
<input type="checkbox"/> Circumcision	<input type="checkbox"/> Surgery _____
<input type="checkbox"/> Medication _____	<input type="checkbox"/> Other (Please explain) _____

5. NUTRITION HISTORY

Please check if the patient has received any of the following items **since birth**:

<input type="checkbox"/> Breast Milk (How long? _____)	<input type="checkbox"/> Juice: Fruit / Vegetable
<input type="checkbox"/> Commercial Formula	<input type="checkbox"/> Medications _____
<input type="checkbox"/> Cow's Milk	<input type="checkbox"/> Solid Foods
<input type="checkbox"/> Goat's Milk	<input type="checkbox"/> Sweets
<input type="checkbox"/> Soy Milk	<input type="checkbox"/> Vitamins _____
<input type="checkbox"/> Other (Please explain) _____	

6. DEVELOPMENTAL HISTORY

Please indicate the age in which the patient performed the following item(s):

<input type="checkbox"/> Respond to Sound Stimuli	<input type="checkbox"/> Crawl
<input type="checkbox"/> Respond to Visual Stimuli	<input type="checkbox"/> Stand
<input type="checkbox"/> Hold Head Up	<input type="checkbox"/> Cruise Furniture
<input type="checkbox"/> Sit Upright	<input type="checkbox"/> Walk
<input type="checkbox"/> Roll Over	<input type="checkbox"/> Run

7. REASON FOR THIS VISIT

Describe the purpose of this visit: _____

When did this condition begin? _____

Please indicate if this condition has/is:

_____ Worsened _____ Constant _____ Better in AM
_____ Improved _____ Intermittent (Comes and Goes) _____ Better in PM

Please indicate if this condition interferes with:

_____ Bowel Movements _____ Eating / Drinking _____ School
_____ Daily Routine _____ Recreational / Play activities _____ Sleeping
_____ Other activities _____

Has this condition occurred before? _____ Yes _____ No

Has the child seen other doctors for this condition? _____ Yes _____ No

If yes, Doctor's Name & Location: _____

Type of treatment: _____

Results: _____

8. CHILD'S HEALTH HISTORY

Please indicate each of the diseases or conditions that the child has now or has had in the past.

_____ Allergies	_____ Eczema / Psoriasis	_____ Scoliosis
_____ Asthma	_____ Fractures	_____ Seizures / Epilepsy
_____ Attention Problems	_____ Growing Pains	_____ Skin Problems
_____ Autism	_____ Hay Fever	_____ Sleeping Problems
_____ Back Pain	_____ Headaches	_____ Speech Problems
_____ Bed Wetting	_____ Hives	_____ Sports Injury
_____ Bowel Movements	_____ Hyperactivity (ADHD)	_____ Stomach Pain
_____ Breathing Problems	_____ Intestinal Gas	_____ Teeth Problems
_____ Chronic / Frequent Colds	_____ Irritability	_____ Temper Tantrums
_____ Colic	_____ Irritable Bowel Syndrome	_____ Tubes In Ears
_____ Constipation	_____ Knee Pain	_____ Urinating (Pain, Smell)
_____ Diarrhea	_____ Nail Problems	_____ Vision Problems
_____ Digestive Problems	_____ Neck Pain	_____ Vomiting
_____ Ear Problems	_____ Recurring Fevers	_____ Walking Problems
_____ Other (Please explain) _____		

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life, (i.e. off a bed, couch, changing table, down stairs, etc)

Was this the case with your child? _____ Yes _____ No

Please indicate if your child has ever had or experienced any of the following & describe details if applicable:

_____ Been Hospitalized? _____
_____ Been in a Car Accident? _____
_____ Had a Serious Fall? (Bicycle, Skateboard, Rollerblades, etc) _____
_____ Had any Broken bones? _____
_____ Had any Surgeries? _____
_____ Has or had any major illnesses? _____

9. VACCINATIONS & MEDICATIONS

Have you chosen to vaccinate your child? _____ Yes _____ No

Please indicate which of the following vaccines your child has received:

_____ DTaP (Diphtheria, Tetanus, Pertusis)	_____ MMR (Measles, Mumps, Rubella)
_____ Gardisil (For Females)	_____ Pneumococcal conjugate (PCV)
_____ Hepatitis B	_____ Polio
_____ Hib (Haemophilus Influenza type B)	_____ Varicella (Chicken Pox)
_____ Influenza	
_____ Other (Please Explain) _____	

Please describe any and all reactions to the vaccines: _____

Please indicate if you have you had any foreign travel (where & when): _____

Please indicate any medications and the dates that your child has or is taking:

_____ Antibiotics	_____ Aspirin	_____ Ibuprofen
_____ Anti-Gas Medicine	_____ Cold Medicine	_____ Tylenol
_____ Other Over-The-Counter Medicine _____		
_____ Other Prescribed Medicine _____		

Has your child had any reactions to any medications? _____ Yes _____ No

If yes, please explain: _____

Name & Location of Pediatrician: _____

Date of last visit: _____ Reason: _____

10. AUTHORIZATIONS & CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my child as the examining and treating doctor deems necessary. If any x-rays are taken they will remain the property of this office. The payment to the office for the x-rays is for the x-ray films and the examination of the x-rays. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care. Any returned checks are subject to a \$30 service charge. I hereby authorize assignment of my insurance rights and benefits (if applicable to the provider for services rendered).

Child's Name

Relationship to child

Parent/Guardian's Name

Date