Pennington Family Chiropractic P.C.

Your spine is your lifeline!

Pediatric Health History

Child's name: _____ Age: _____ Date of Birth: ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Mother's name: _____ Father's name: _____

Phone #: _____ Email: _____ ☐ Male ☐ Female

Reason for contacting our office: _____

Whom may we thank for referring you to our office? _____

Who is your: Medical Doctor: _____ | OB/GYN: _____

Health Profile

Why is this form important? As a family chiropractic office, we focus on you and your child's ability to achieve the highest level of health. Our goals are to:

1. Address the issues that brought in to our office, and
2. To offer you and your child the opportunity of improved and continued health.

If your child has no symptoms or complaints, and is here for wellness care, please ☐ **check here** and go to page 2.
If there is a main complaint, please describe here, including the effect it has on your child:

_____

_____

When did the pain/problem start? __/__/____ | Is it getting: ☐ **Better** |☐ **Worse** |☐ **Staying the same**

If he/she is experiencing pain, is it: ☐ **Sharp**|☐ **Dull** |☐ **Comes and goes** |☐ **Travels** |☐ **Constant**

What makes it worse? _____

What makes it better? _____

Is it worse at certain times? ☐ **Morning**|☐ **Afternoon**|☐ **Before bed** |☐ **Night** |☐ **Constant** |☐ **Other**

It interferes with: ☐ **School**|☐ **Sleep**|☐ **Walking**|☐ **Sitting**|☐ **Eating**|☐ **Focusing**|☐ **Other:** _____

Other healthcare professionals consulted: ☐ **Medical physician** | ☐ **Acupuncturist**

☐ **Homeopath** | ☐ **Naturopath** | ☐ **Massage therapist** | ☐ **Other:** _____

Has he/she taken or done anything for this problem? ☐ **Yes** ☐ **No** If yes, what?

_____

_____

List medications, vitamins and/or supplements the child is taking:

_____

_____

Daily we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow for a more complete assessment to any challenges to your child's health potential. Please answer to the best extent possible.

Pregnancy

Were there complications during the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? ☐ **Yes** ☐ **No**

If yes, please list: _____

Did **any** member of the household smoke during the pregnancy? ☐ **Yes** ☐ **No** Who? _____

Was the baby ever in a breech position? ☐ **Yes** ☐ **No** How many ultrasounds were performed? _____

Birth and Delivery

Where was the baby born? ☐ **Home** | ☐ **Hospital** | ☐ **Birthing center** | ☐ **Other:** _____

Was the delivery: ☐ **Vaginal** | ☐ **C-section** Were any devices used? ☐ **Vacuum** | ☐ **Forceps**

Was an epidural administered? ☐ **Yes** ☐ **No** Was pitocin used? ☐ **Yes** ☐ **No**

How long was the labor? _____ |What was the child's birth weight? _____ lbs. _____ oz.

Infancy

Was there any use of any medicines (antibiotics or otherwise) or an inhaler? ☐ **Yes** ☐ **No**

If yes, please describe: _____

Did the infant have any severe traumas such as a serious fall or car accident? ☐ **Yes** ☐ **No**

If yes, please describe: _____

For how long was the child fed with: Breast milk: _____ Bottle: _____ Formula (type): _____

Did the infant have previous chiropractic care? ☐ **Yes** ☐ **No**

Childhood

Was the child vaccinated? ☐ **Yes full schedule** ☐ **Yes partial/delayed schedule** ☐ **No**

Did the child have any childhood illnesses? ☐ **Yes** ☐ **No** Explain: _____

Does the child play any youth sports? ☐ **Yes** ☐ **No** Which sport(s)? _____

Has the child had any surgeries? ☐ **Yes** ☐ **No** Explain: _____

Has the child fallen from a height over 3 ft.? ☐ **Yes** ☐ **No** Explain: _____

Has the child been in any car accidents? ☐ **Yes** ☐ **No** Explain: _____

Has there been any use of medications? ☐ **Yes** ☐ **No** Explain: _____

Has the child suffered emotional trauma? ☐ **Yes** ☐ **No** Explain: _____

Any additional health information you feel would be helpful: _____

_____

Consent for care: *The statements on this form are accurate to the best of my knowledge. I have legal authority and hereby give consent to Pennington Family Chiropractic, P.C. to examine and provide chiropractic care for my child.*

Parent or Guardian Signature: _____ Date: _____