Alignment Specific
CHIROPRACTIC CLINIC

Pediatric Health History form:

Child's Name:_____ Age:_____ Date:_____

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

Mother's Name: _____ Father's Name: _____

Mother's Phone #: _____ Father's Phone #: _____

Child's Birth Date: _____ Male/Female (circle one) SSN:_____

Reason for consulting our office?: _____

Whom may we thank for referring you?: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of last Visit: _____ Purpose: _____

Health Profile:

Why is this form so important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals at first are:

1. Address the issues that brought you to this office,
2. Offer you and your child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you into this office:

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐

If you came in today for a specific complaint, please fill out the next portion briefly describing it:

If he/she is experiencing pain, is it (check all that apply):

☐ Sharp ☐ Shooting ☐ Travels

☐ Burning ☐ Aching ☐ Worse with movement

☐ Dull ☐ Burning

☐ Comes and Goes ☐ Constant

Since the problem started is it: ☐ Same ☐ Better ☐ Getting Worse

What makes it worse? _____

What does it interfere with? _____

Who else have you seen for the issue? _____

- Has it helped? _____

List medications the child is currently taking:

_____

_____

Past surgeries or traumas:

_____

_____

Number of doses of antibiotics the child has taken recently (within 6months):

_____

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 us to better assess the challenges to your child's health potential.

Pregnancy:

Third trimester presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow

Were there any complications to the pregnancy? _____

Was mom on any medications (prescription or over the counter)? _____

- If yes, please explain: _____

Did mom or dad ever smoke during pregnancy? Yes/No (circle one) Who? _____

How many ultrasounds were performed? _____

Birth and Delivery:

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

Was the delivery: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum/ Suction Cap

Approximately how long was labor? _____ Delivery? _____

Was oxytocin/Pitocin used? Yes/No (Circle one) Was an epidural used? Yes/No (Circle one)

Apgar Scores: _____ _____

Congenital Anomalies/Defects?

_____

_____

Infancy:

Was the infant vaccinated? Yes/No (Circle one) If Yes, List them with dates or provide vaccination card:

_____

_____

_____

Infant feeding: ☐ Breast ☐ Formula, Which? _____

Number of hours sleeping per night? _____

Quality of Sleep? ☐ Good ☐ Fair ☐ Poor

Was there any prolonged use of medications or an inhaler? Yes/No (Circle one)

- If yes, Explain: _____

Did the infant suffer any traumas such as serious falls or car accidents?

Yes/No (Circle one) If yes, Explain: _____

Has the infant ever been under regular chiropractic care? Yes/No (Circle one)

Childhood years:

Did the child have any childhood illnesses? Yes/No (Circle one)

- If yes, Explain: _____

Does the child play any youth sports? Yes/No (Circle one)

- If yes, which one(s)? _____

Has the child suffered from emotional traumas? Yes/No (Circle one)

Please give us any other health information you feel would be helpful:

_____

_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to Alignment Specific Chiropractic Clinic to examine and care for my child.

Guardian's Signature: _____

Relationship to child? : _____

Date signed: _____