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CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

General Information

Parent/Guardian Name:		Child Name:		Date:	
Child Date of birth:		Child Age:			
Child Height:		Child Weight:			
Address:					
Street		City		State Zip	
Home phone:			Work phone:		
Cell phone:			Email address:		
Best time/place to contact you:					
Are you interested in receiving a health e-newsletter (free in your email)? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Who may we thank for referring you?					

Addressing What Brought Your Child Into This Office:

If your child has no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "Childs General Health History".

Health Concerns If none, skip to "Child's General Health History"

Please list your child's health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is their pain dull? Or is their pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your child's condition?

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your child's life due to this pain, illness, condition, etc? (i.e., eat better, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following?

School <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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Child's General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Has your child had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Has your child had any accidents and/or injuries: auto, school-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Has your child ever had x-rays taken?

Area of body:	When?	Where?
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Does your child wear orthotics or heel lifts? Yes No

Child's Current Medicines and Supplements

Please list any medications/drugs your child has taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently give your child and why:

Are you interested in your child knowing more about how nutrition (food they eat) affects their overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your child's diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you give whole food supplements to your child if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your child's program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help your child would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Child's Diet

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Water	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet my child usually follows is classified as: _____

Child's Past Health History

Please mark the following conditions your child may have had or have now (- have had + have now):

<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Eczema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Migraines	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Child's Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (your child has ever had) in each category:

1. **Physical stress** (falls, accidents, work postures, etc.)

- a. _____
- b. _____
- c. _____

2. **Bio-chemical stress** (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. _____
- b. _____
- c. _____

3. **Psychological or mental/emotional stress** (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____
- c. _____

On a scale of 1-10 please grade your child's present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At school:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your child's:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your child's physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your child's emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Did the child's mother have complications during this child's pregnancy, labor, or delivery? Please explain if child is under 10 years old.

Have there been any developmental problems during this child's life? Please explain.

Is there anything else which may help to better understand your child which has not been discussed?

Why are you bringing in your child here at this point in time?

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Print Guardian Name: _____

Signature: _____