We are committed to adjust and inspire families to achieve their innate health potential, especially children. Through learning and living the chiropractic lifestyle people of all ages will experience abundant health, vitality and happiness.

CONFIDENTIAL PATIENT HEALTH RECORD
CHILDREN **Date / /**

Patient Introduction

Personal History:

Patient Name: _____
First Middle Last

Mom and Dad's Names: _____

Address: _____

Telephone: Home: _____ Other: _____ Email: _____

Birth Date: Day _____ Month _____ Year _____ Age _____

Previous Chiropractor: _____ City: _____

Last Adjustment: _____ Past Schedule of Care: _____

Reason for Leaving: _____

Present MD: _____ City: _____

How Did You Hear About Our Office?: _____

What Made You Choose to Come to Our Office?: _____

_____

Child and Adolescent Health Questionnaire

This part is mainly for Moms:

1. **Tell us about your pregnancy:**

   Did you carry full term? _____ If not, how many weeks gestation? _____

   Describe any complications that occurred: _____

   _____

2. **Tell us about your delivery and birth of your child:** _____

   _____

   Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

   Did you have a C– Section? _____ Were forceps used? _____ Vacuum extraction? _____

   Were you induced? _____ Did you have an epidural? _____ Was it a difficult birth? _____

   Were any drugs given to mom or baby during or after delivery? _____

   What was the baby's **APGAR** score at 1 minute? _____ /10 at 5 minutes _____ /10

   Was there initial respiratory delay? _____ Purple markings on face or neck? _____

   Misshapen head or skull? _____

3. **Tell us More:**

   Did you breastfeed? _____ For how long? _____ What formula after? _____

   Did you consume alcohol, cigarettes, medications or other drugs during your pregnancy?

   _____ How Much _____ How Long? _____

   Any exposures to ultrasound? _____ How many? _____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of a crib
___ Involved in a car accident
___ Fall off playground equipment
___ Play in “Jolly Jumper”
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other _____

Please explain the above: _____
_____
_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall off playground equipment
___ Sports accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Leg/knee pains
___ Other _____

Please explain the above: _____
_____
_____

6. Tell us about any vaccinations your child has had:

_____
_____

Any reactions to any of these? _____

Were you told that you had a choice in vaccinating your child? __ **Yes** ___ **No**

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbnesss in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ “Growing Pains”
___ Other _____

Please explain the above: _____
_____
_____

8. **Which of the problems you have checked off is the worst?** _____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic __

9. **How long has it persisted?** _____

10. **When it is at its worst, how does it make you feel?** _____
_____

11. **What have you done about it that has NOT worked?** _____
_____
_____

12. **What makes it worse?** _____

13. **What effect does this problem have of your child's body functions?** _____
_____

On his/her participation in daily activities?_____

14. **Describe any hospital stays:** _____
_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?**
_____
_____

16. **List any medications your child is currently taking:** _____
_____

17. **To summarize, what is your purpose for this appointment?** _____
_____
_____
_____
_____

18. **Is there anything else you feel we should know?** _____
_____
_____
_____
_____

_____ _____

(Signature of Parent or Guardian) (Date)

Thank You!