

CHIROPRACTIC PEDIATRIC HEALTH ASSESSMENT

Name: _____ Age ____ Date of birth _____
Parent's Name: _____
Address: _____
Town _____ Zip _____
Home Phone: _____ Work phone _____

Please answer the following questions that are designed to help maximize your child's health. Many types of stress (physical, mental, and chemical) can interfere with your child's growing spine and nerve system. Spinal health is an exciting new concept for many people, so please ask questions.

Reason for visit to our office: _____

Birth and Prenatal History:

Birth Place: YHome YHospital YBirth Center YMid-Wife

Type of Delivery: YVaginal YC-Section APGAR score: at birth ____ after 5 min ____

Interventions: YForceps YVacuum Extraction YEpidural

Complications of delivery: _____

Medications during delivery: _____

Ultrasounds during pregnancy: _____

Feeding:

Breast fed? YYYN How long? ____ Did he/she nurse equally to each breast? YYYN

Is there any intolerance or allergy to formula or foods? YYYN List _____

Did you supplement the bottle with cereal? ____ If yes, at what age? _____

Age began solid foods: ____ What types? _____

Does your child eat: sweets ____ Foods with artificial sweeteners ____ Drink soda: ____

Does your child take vitamins or supplements? ____ Which ones? _____

Developmental Milestones:

At what age did your child: Respond to sound: ____ Respond to visual cues: ____

Hold their head up: ____ Sit up: ____ Sit up without support: ____

Crawl on all fours: ____ Stand alone without support: ____ Walk: ____

Ride a bike: _____

Please complete reverse side => => =>

According to the National Safety Council approximately 50% of infants fall headfirst from a high place (bed, couch, changing table) during their first year of life. Has this happened to your child? _____

**Has either a doctor or hospital seen your child on an emergency basis? _____
Explain: _____**

Has your child had surgery? _____

Does your child have any learning challenges? _____

Which sports/activities does your child participate in? _____

Check any of the following your child has had during the past 12 months:

**YEar infections YScoliosis YChronic cold YAsthma YAllergy YColic YEczema
YPsoriasis YDiabetes YBedwetting YSeizures YVisual impairmentYADD/ADHD
YRecurring fever YDigestive problems YTemper tantrums YGrowing pains
YHeadache YSubluxation YBack aches**

**Has your child had: YChicken pox YRubella YRubeola YMumps YMeasles YRoseola
Y5th s Disease YWhooping Cough - other _____**

**Number of prescription drugs your child has taken:
Over the past 12 months? ____ In his /her lifetime? ____
Types: _____**

**Number of non-prescription drugs your child has taken:
Over the past 12 months? ____ In his/her lifetime? ____
Types: _____**

**We understand that not all parents wish to immunize their children. Has your child
been immunized? _____ If yes, what age was the first vaccine? _____ Has your child
ever had a reaction of any kind to an immunization? _____ If yes what type of
reaction? _____**

I hereby authorize the doctors at this office to examine and provide care for my child.

Signed: _____ (Parent or Guardian) Date: _____