FOCUSED HEALTH
Chiropractic

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Pediatric Patient Information

Child's Name:____ Date:________________________

Gender:________ Date of Birth:___________________ Age:_________ School Grade:_______________

Home Phone:_________________________________

Parent E-Mail Address:____

Address:____________________________________City:____________________ State:_____Zip________

Mother's Name:____ Cell/Work Phone:____________________

Father's Name:____ Cell/Work Phone:____________________

Purpose of this appointment:____

Pediatrician:____ Phone:____________________________

Mother's Pregnancy History (if child is adopted, answer to the best of your ability)
Select any of the following you experienced during your pregnancy:

____Severe viral infection during first trimester
____Breech position during pregnancy
____Accident or infections
____Smoking
____Severe stress
____Pre-eclampsia
____Alcohol consumption and/or drug use
____Radiation exposure
____Hypertension (high blood pressure)
____Toxoplasmosis
____Uncontrolled diabetes
____Toxemia

Mother's Labor & Delivery History
Select any of the following you and/or the child experienced during labor/delivery:

____Hospital Birth
____Birthing Home
____Long and/or difficult labor
____Placenta Previa
____ Forceps or suction cups used
____Fetal distress
____Elective C-Section
____ Child was a "blue baby"
____Home Birth
____Induced Labor
____ Rapid delivery
____Breech birth
____ Cord around the neck
____Emergency C-Section
____Premature delivery (2+ weeks)

Comments:____

____

Newborn History

Select any of the following that your child experienced as a newborn:

____Required resuscitation/oxygen
____Prolonged jaundice
____Poor sleeper
____ Immunizations in hospital
If yes, specify vaccine:______________________
____
Weight at birth:___________________________

____Distorted skull
____Difficulty latching/sucking
____ Formula fed
____Breast fed
____Bottle fed
____Colic
Length at birth:__________________________

Health History

Select any of the following that your child has experienced or been diagnosed with:

____Illnesses accompanied by high fever
____Frequent headaches
____Seizures/convulsions
____Chronic ear infections/earaches
____Head injury
____Serious fall(s) or repetitive falls
____Epilepsy
____Meningitis
____Allergies to foods
____Environmental allergies
____Chemical sensitivities
____Surgery
____Neck or back problems
____Adverse reaction to any vaccinations (even mild)

____Dizziness
____Diabetes
____Hypoglycemia (low blood sugar)
____Trouble with bladder control (enuresis)
____Fainting
____ High blood pressure
____ Heart disease
____Asthma
____Sinus problems
____Constipation
____Diarrhea
____Digestive disorders
____Rheumatic fever
____Joint or muscle problems

If yes, please explain____

Developmental History

Select all that apply or did apply:

____Difficulty crawling (on all fours)
____Difficulty learning to ride a bike
____Difficulty learning to read
____Difficulty using utensils
____Difficulty tying shoes
____Poor hand-eye coordination

____Did not crawl on all fours
____Appears clumsy
____Difficulty with writing
____Difficulty buttoning clothes
____Difficult or awkward when walking/running
____Difficulty sitting still or paying attention

____Age that your child started to walk unassisted:________

Comments:____

____

Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following? If yes, by whom?

____Hearing loss or impairment
____Neurological disorders
____Obsessive Compulsive Disorder (OCD)
____ADD/ADHD
____Dyslexia
____Visual Impairment
____Anxiety/Depression requiring treatment
____Autism/Autism Spectrum Disorder
____Tourette's Syndrome
____Other

Current/Past Medications and Treatments

List any medications your child is taking
List names, dosage and frequency)

____

____

List any special dietary needs that your child has:

____

____

List any supplements your child takes:

____

____

List any treatment that your child is currently undergoing with any health professional

____

____

List any special services that your child is currently receiving at school or privately

____

____

List any previous alternative treatment, medications or other medical treatment that your child has undergone:_________________________________

____

Main Condition/Symtpoms:____

Other conditions/symptoms:____

How long has your child had these conditions/symptoms?____

Height: ____feet ____inches Weight:_______

Last known blood pressure______ / _____ Hypertension: ____Yes ____No

Surgeries____ Approx Dates:_____________________

Hospitalizations____ Approx Dates:_____________________

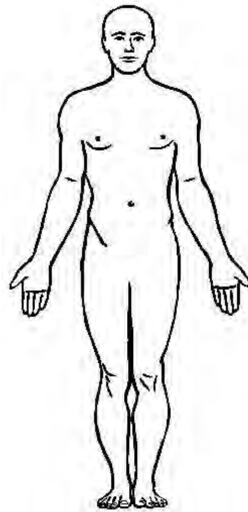
Major Illnesses:____ Approx Dates:_____________________

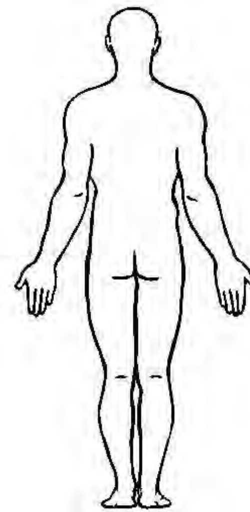
Diabetes: ____Yes* ____No *IF yes: ____Type I ____Type II

CURRENT COMPLAINTS

On the diagram, please indicate the location of pain and symbol that best describes what your child is experiencing:

SHARP/STABBING	++++
DULL/ACHEY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////





Does your child have pain every day? ____Yes ____No

Does your child's pain wake you at night? ____Yes ____No

Are your child's symptoms: ____Worsening ____Unchanged ____Improving

What increases your child's pain?____

What decreases your child's pain?____

Has your child seen other doctors for this condition? If so, who?_________________________________

Date of last physical exam:_____________________________

Date of last spinal X-rays/MRI's: ________________________

Has your child had previous chiropractic care? ____Yes ____No