Sleigh Family Chiropractic

Pediatric Health History

Today's Date:_____

PATIENT INFORMATION:

Child's Name:_____ Child's Nickname:_____

Present Health Challenge:_____

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health: _____

_____

How do you feel your child's present health challenge effects his/her overall health and his/hers ability to experience an optimal quality of life? _____

_____

Do you feel your child's environment is related to his/her present challenge? _____

Do you feel your child's present diet is related to his/her present health challenge? _____

Date of Birth:_____ Age:_____

Child's Address and Phone (if different from yours): _____

Who may we thank for referring you?_____

FAMILY INFORMATION:

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

Address:_____ Address: _____

_____ _____

Cell Phone:_____ Cell Phone:_____

❑ I would like to opt out of receiving SMS messages and appointment reminders. I understand that Sleigh Family Chiropractic will no longer be able to communicate with me through SMS text messaging.

Parents Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

List ages of other children in family:_____

Predominant language used at home:_____

PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name:_____Birth Date:_____

Insurance Company:_____ Group #:_____ ID:_____

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

PREGNANCY HISTORY

What was the term of your pregnancy? _____ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

Yes/No

Falls _____	Motor Vehicle Accidents _____
Near-miss MVA _____	High Blood Pressure _____
Diabetes _____	Anemia _____
Morning Sickness _____	Indigestion _____
Seizures _____	Swollen Ankles _____
Thyroid Problems _____	Heart Problems _____
Back Pain _____	Abnormal Bleeding _____
Were you Hospitalized _____	Any Other Illnesses (list) _____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

Yes/No

Tobacco _____ Alcohol _____

Non-Prescribed Drugs _____ Prescription Medications _____

Over-the-counter meds (list) _____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

Yes/No

Hospital Birth _____ Home Birth _____

Midwife Assisted _____ Vaginal Delivery _____

Planned C-Section _____ Emergency C-Section _____

Was Birth Induced _____ Forceps Delivery _____

Vacuum Extraction _____ Anesthesia Administered _____

Fetal Distress _____ Meconium Staining _____

Head Presentation _____ Face Presentation _____

Breech Presentation _____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH: (If Known)

Apgar Scores: At 1 minute _____/10 At 5 minutes _____/10

Baby's Crying: Baby Cried Immediately After Birth _____ Cried Strongly _____

Weak Cry _____ Did Not Cry for _____minutes

Baby's Color: Pink All Over _____ Blue Face _____ Blue Hand / Feet _____

Baby's Activity: Arms and Legs Actively Moving _____ Floppy Baby _____

Intensive Care Was Required _____ Days in Neonatal Intensive Care Unit _____

Medication Given at Birth? _____

Vaccines Administered _____

_____

Birth Weight _____lbs / kgs Birth Length _____ ins / cms Baby Home on Day _____

INFANT HISTORY

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION:

If yes, please explain: _____

Is your child still being breast fed? If no, for how long was he / she breast fed? _____

If still breast feeding, how much cow's milk does the mother consume each day? _____

Is your child formula fed? Which formula or other milk source? _____

Is your child eating solid food? What foods does his / her diet contain? _____

What is your child's favorite food? _____

Does your child have any feeding difficulties? _____

Does your child have any digestive disturbances?_____

Does your child have any food allergies? _____

Does your child have any persistent or intermittent skin rashes? _____

Is your child receiving any vitamin supplements? _____

TRAUMA:

Has your child had any recent falls or trauma? (What and When)_____
Has your child ever fallen down stairs or fallen from any height? (Where and When)_____
Has your child ever been in a motor vehicle collision or near-miss? (What and When)_____
Has your child ever had a bone fracture or joint dislocation? (Where)_____
Has your child had any other trauma or injuries? (Describe)_____
Does your child ever bang his / her head repeatedly against a wall, bed or other object? _____

GROWTH AND DEVELOPMENT:

Can your child sit unsupported? At what age did your child start to sit-up? _____ months
Is your child crawling yet? At what age did your child start crawling? _____months
Is your child walking yet? At what age did your child start walking? _____months
Does your child often trip and fall? _____
Do you have any other concerns about your child's growth and development? _____

HEALTH HISTORY:

Does your child ever complain of back or neck pain? _____
Does your child ever complain of pains in the arms or legs? _____
Does your child ever complain of headaches? _____
Has your child had any earaches? At what age did the first earache occur? _____
How frequently does your child have earaches? _____
Do your child's earaches usually tend to occur in the same ear? Is it the right or left ear? _____

Which of the following has your child experienced? Indicate "C" (current) or "P" (past):

___ Skin conditions	___ Digestive complaints	____ Growing pains
__ Easy bruising	___ Difficulty sleeping	____ Allergies
__ Colic	___ Seizures	____ Pneumonia
__ Asthma	___ Constipation	____ Diarrhea
__ ADD/ADHD	___ Autism	____ Learning disabilities
__ Sinus troubles	___ Nausea/Vomiting	____ Upper Respiratory Infections
__ Bed wetting	___ Chicken pox	____ Mononucleosis
__ Impetigo	___ Measles	____ Bronchitis
__ Frequent infections	___ Strep throat	____ Thrush
__ Diaper rash	___ Urinary tract infections	____ Asthma

Has your child had any other illnesses? Please list each illness and its approximate date_____
_____
Is your child presently receiving any medications? _____
Has your child ever been to a hospital or emergency room for evaluation or treatment? _____
Has your child recently been vaccinated? _____
Do you have any other concerns about your child's health? _____

Any Other Important Info:

_____
_____
_____
_____

✓We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
✓Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
✓I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
✓I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in medical status.

Signature _____ Date: _____

Relationship to Patient _____