632 Maine Street
Quincy, IL 62301
217-779-6504

Thrive CHIROPRACTIC

Pediatric Health History Form

Child's Name:_____ Date:_____

Child's Age:_____ Date of Birth:_____ Sex: M F

Parent's Names:_____ Sibling's names and ages:_____

Email address:_____

Home address:_____

Phone: (H)_____ (W)_____ (C)_____

Who may we thank for referring you?_____ Has your child ever received chiropractic care**?** **YES NO** If yes, list the previous Doctor of Chiropractic:_____

Family doctor's name and address:_____

WHY THIS FORM IS IMPORTANT: Our focus is on assisting your child to function optimally, become healthier and improve his/her ability to adapt to everyday stresses. Completion of this form provides us with an improved understanding of his/her physical, chemical and emotional stresses that can gradually overwhelm the body and contribute to health concerns. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.

1. Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness, check this box) ☐

Health concern:_____

_____

When did this problem begin?_____

Describe what happened:_____

How often does it occur?_____ What relieves it?_____

What aggravates it?_____ Does it radiate to other parts of the body?

_____ Other professionals seen for this:_____

Is this problem worse during a certain time of the day? **YES NO** If yes, when?_____
Does this interfere with the child's sleep? **YES NO** Eating? **YES NO** Daily routine? **YES NO**

Is this becoming worse? **YES NO**

Other health concerns: Please note all other health concerns in the past (P) or current (C).

P	C		P	C		P	C	
☐	☐	ADD/ADHD	☐	☐	Epilepsy	☐	☐	Migraines
☐	☐	Allergies	☐	☐	Fainting	☐	☐	Muscle cramps
☐	☐	Asthma	☐	☐	Fatigue	☐	☐	Neck pain
☐	☐	Appendicitis	☐	☐	Fevers	☐	☐	Night sweats
☐	☐	Autoimmunity	☐	☐	Frequent colds/sickness	☐	☐	Numbness in feet
☐	☐	Bedwetting	☐	☐	Headaches	☐	☐	Numbness in hands
☐	☐	Bloating	☐	☐	Heart disease	☐	☐	Pneumonia
☐	☐	Bronchitis	☐	☐	Heartburn	☐	☐	Poor coordination
☐	☐	Cancer:_____	☐	☐	Hepatitis	☐	☐	Juvenile RA
☐	☐	Colic	☐	☐	Hernia	☐	☐	Shortness of breath
☐	☐	Congenital defect	☐	☐	Hyperactivity	☐	☐	Sleeping problems
☐	☐	Constipation	☐	☐	Hypoglycemia	☐	☐	Stiffness
☐	☐	Developmental delays	☐	☐	Indigestion	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Kidney disease	☐	☐	Thyroid issues
☐	☐	Diarrhea	☐	☐	Lightheadedness	☐	☐	Tonsillitis
☐	☐	Digestive issues	☐	☐	Liver disease	☐	☐	Ulcerative colitis
☐	☐	Dizziness	☐	☐	Low back pain	☐	☐	Urinary problems
☐	☐	Ear infections	☐	☐	Mid back pain	☐	☐	Urinary tract infection
						☐	☐	Other:_____

2. Family Health History: Please note if your child's mother (M), father (F), brother (B), sister (S) or grandparent (G) have or have had any of the following conditions.

Arthritis_____	Diabetes_____	Menstrual disorder_____
Asthma_____	Digestive issues_____	Migraines_____
ADD/ADHD_____	Disc problems_____	Neck pain_____
Allergies_____	Ear infections_____	Scoliosis_____
Back troubles_____	Fibromyalgia_____	Shoulder pain_____
Bed wetting_____	Headaches_____	Sinus issues_____
Cancer_____	High blood pressure_____	Stroke_____
Carpal tunnel_____	Hip pain_____	TMJ disorder_____

3. Birth History:

What was the child's gestational age at birth?_____weeks Birth weight:_____lbs _____oz

Birth length:_____inches Was the child born breech? **YES NO**

Duration of birth:_____hours Were there any complications? **YES NO** If yes, please explain:_____

Were any assistances used during delivery? **FORCEPS VACUUM EPISIOTOMY C-SECTION**

Was labor spontaneous or induced?_____
Were medications or epidurals given to mother during birth? **YES NO**

Was the APGAR score in the healthy range? **YES NO**

Is there anything else we need to know about the birth? **YES NO** If yes, please explain:_____
_____

4. Growth and Development:

Did the child reach all milestones at the appropriate time? **YES NO** If no, please explain:_____
_____

Does the child sleep on his/her: **FRONT BACK SIDE** Do you consider the child's sleeping patterns to be normal? **YES NO** If no, please explain:_____

3. Physical Stresses:

Any traumas to the mother during pregnancy? **YES NO** If yes, explain:_____
_____

Any evidence of birth trauma to the infant? **BRUISING STUCK IN BIRTH CANAL RESPIRTATORY DISTRESS ODD SHAPED HEAD FAST OR LONG BIRTH CORD AROUND NECK** Other:_____

Any significant falls from couches, beds, changing tables, etc? **YES NO** If yes, explain:_____
_____

Any traumas resulting in bruises cuts, stitches or fractures? **YES NO** If yes, explain:_____
_____

Any hospital visits or surgeries? **YES NO** If yes, explain and dates:_____

Any sports played? **YES NO** If yes, list:_____

Do you feel your child's backpack is too heavy? **YES NO**

Give your child a score from 0-10 on the overall physical stresses in your life (0=no physical stress, 10=maximal physical stress)_____

4. Chemical Stresses:

Was the child breastfed? **YES NO** If yes, how long?_____

Formula introduced? **YES NO** If yes, at what age?_____ Food introduced at what age?_____

Food allergies or intolerances? **YES NO** If yes, list:_____
Is the child on prescription or over-the-counter medications? **YES NO** Name of medication and reason_____
_____

Did the mother do any of the following during pregnancy? **SMOKE DRINK ALCOHOL MEDICATION** If yes, explain:_____

Any antibiotics given? **YES NO** If yes, explain:_____

Does the child eat processed food, junk food, fast food, etc. regularly? **YES NO OCASSIONALLY**

Does the child drink soda, energy drinks, or sports drinks regularly? **YES NO OCASSIONALLY**

Do you use natural products in the home (skin care, hair care, cleaning supplies, etc.)? **YES NO**

Give your child a score from 0-10 on the overall chemical stresses in his/her life (0=no chemical stress, 10=maximal chemical stress)_____

5. Mental/Emotional Stresses:

Any problems with bonding? **YES NO** If yes, explain:_____

Any behavioral problems? **YES NO** If yes, explain:_____

Any difficulties at daycare or school? **YES NO** If yes, explain:_____

Any learning deficiencies? **YES NO** If yes, explain:_____

Any night terrors, sleep walking or difficulty sleeping? **YES NO** If yes, explain:_____

Any prolonged temper tantrums or separation anxiety? **YES NO** If yes, explain:_____

Average number of hours of television/video games per week?_____

Does your child have a cell phone/iPod/iPad?_____

Give your child a score from 0-10 on the overall mental/emotional stresses in his/her life (0=no mental/emotional stress, 10=maximal mental/emotional stress)_____

6. Reason you are here:

People seek chiropractic care for a number of reasons and have certain expectations. Please indicate your reason for choosing chiropractic.

☐ Wellness ☐ Improved quality of life ☐ Prevention ☐ Improved function ☐
Improved performance ☐ Drug-free healthcare ☐ Improved immune system ☐ Pain reduction ☐ Symptom reduction ☐ Other:_____

Authorizing consent for examination of a minor: Please read carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's case for care, I acknowledge and understand that a complete and thorough evaluation must be performed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in my child's interests.

Name:_____ Date:_____

Signature:_____ Witness:_____

Doctor of Chiropractic:_____