



# CONFIDENTIAL PEDIATRIC HEALTH RECORD

**NEW PATIENT**  
**REACTIVATE**  
**OTHER**

PLEASE PRINT:

DATE: \_\_\_\_\_

CHILD'S FULL NAME \_\_\_\_\_ PARENT'S HOME PHONE \_\_\_\_\_

PARENT'S FULL NAME \_\_\_\_\_ PARENT'S WORK PHONE \_\_\_\_\_

PARENT'S STREET/P.O. ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

WHAT IS YOUR CHILD'S BIRTHDATE? \_\_\_\_\_ HOW OLD IS YOUR CHILD? \_\_\_\_\_ CHILD'S S.S.# \_\_\_\_\_



## HISTORY OF THE PRESENT ILLNESS/INJURY

PLEASE BE SPECIFIC:

### CHIEF COMPLAINT

#### PLEASE DESCRIBE YOUR CHILD'S PAIN OR CONDITION

PLEASE BE SPECIFIC: CONSTANT, COMES AND GOES, GETTING BETTER/WORSE, STAYING THE SAME, ETC.

FOR WHAT CONDITION ARE YOU CONSULTING THE DOCTOR? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

WHEN DID IT BEGIN? \_\_\_\_\_

SINCE THAT TIME, HAS THE PROBLEM GOTTEN  BETTER  WORSE  STAYED THE SAME?

HOW DID IT OCCUR? \_\_\_\_\_

DO THE SYMPTOMS CHANGE WITH THE TIME OF DAY? \_\_\_\_\_

LIST ANY VISIBLE BUMPS, SCRAPES, CUTS, ETC. ON YOUR CHILD: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

YES NO

HAS THERE BEEN A CHANGE IN YOUR CHILD'S EATING HABITS? IF SO, WHAT? \_\_\_\_\_

HAS THERE BEEN A CHANGE IN YOUR CHILD'S SLEEPING HABITS? IF SO, WHAT? \_\_\_\_\_

DOES YOUR CHILD CRY IF A PARENT ATTEMPTS TO CHANGE ITS SLEEPING POSITION? \_\_\_\_\_

DOES YOUR CHILD WAKE UP CRYING FREQUENTLY AT NIGHT? \_\_\_\_\_

ARE THERE ANY OTHER ALTERATIONS OF YOUR CHILD'S NORMAL SLEEP PATTERNS? \_\_\_\_\_

DOES YOUR CHILD HAVE A FEVER OF UNKNOWN ORIGIN? \_\_\_\_\_

DOES YOUR CHILD HAVE A LOSS OF APPETITE OR OTHER RECENT EATING DISORDERS? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DOES YOUR CHILD HAVE A RECENT CHANGE IN "BATHROOM" HABITS? \_\_\_\_\_

HAS YOUR CHILD RECENTLY BECOME IRRITABLE / RESTLESS / GRUMPY, ETC.? \_\_\_\_\_

#### WHAT MAKES THE CONDITION BETTER?

HEAD NECK \_\_\_\_\_

MID BACK \_\_\_\_\_

LOW BACK \_\_\_\_\_

SHOULDER, ARM, HAND \_\_\_\_\_

HIP, LEG, FOOT \_\_\_\_\_

OTHER \_\_\_\_\_

#### WHAT MAKES THE CONDITION WORSE?

HEAD NECK \_\_\_\_\_

MID BACK \_\_\_\_\_

LOW BACK \_\_\_\_\_

SHOULDER, ARM, HAND \_\_\_\_\_

HIP, LEG, FOOT \_\_\_\_\_

OTHER \_\_\_\_\_

#### LEVEL OF HISTORY OF PRESENT ILLNESS/INJURY (OFFICE USE ONLY)

\_\_\_\_\_ BRIEF (01, 02, 12, 13)

\_\_\_\_\_ EXTENDED (03, 04, 05, 14, 15)

#### NATURE OF PRESENTING PROBLEM (OFFICE USE ONLY)

\_\_\_\_\_ MINIMAL (11)

\_\_\_\_\_ LOW SEVERITY (02, 13)

\_\_\_\_\_ HIGH SEVERITY (04, 05, 15)

\_\_\_\_\_ MINOR/SELF LIMITED (01, 12)

\_\_\_\_\_ MODERATE SEVERITY (03, 14)



## PAST MEDICAL HISTORY

YOUR CHILD'S BIRTH:

WAS THE CHILD'S DELIVERY  VAGINAL OR  CESAREAN? \_\_\_\_\_

WAS THE CHILD BORN  HEAD DOWN  BREECH OR  SHOULDER DOWN? \_\_\_\_\_

YES  NO WERE EXTRACTION AIDS (FORCEPS/SUCTION) USED DURING DELIVERY? \_\_\_\_\_

YES  NO WAS LABOR PROLONGED? HOW LONG WAS LABOR? \_\_\_\_\_

YES  NO WAS THERE MORE THAN ONE FETUS? \_\_\_\_\_

YES NO  
  HAS YOUR CHILD EVER SEEN A CHIROPRACTOR BEFORE? WHEN? \_\_\_\_\_  
 DOCTOR'S NAME AND LOCATION: \_\_\_\_\_  
 FOR WHAT CONDITION? \_\_\_\_\_  
 HOW MANY TIMES HAVE YOU HAD THIS CONDITION BEFORE? IF YES,  0-3 TIMES?  4 OR MORE TIMES? \_\_\_\_\_

HAS YOUR CHILD EVER SEEN ANYONE ELSE FOR THIS CONDITION? WHEN? \_\_\_\_\_  
 WHERE TREATED? \_\_\_\_\_ BY WHOM? \_\_\_\_\_  
 RESULTS: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

ALLERGIES? TO WHAT? \_\_\_\_\_

DOES YOUR CHILD TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?

HAS YOUR CHILD EVER BEEN IN AN AUTOMOBILE ACCIDENT?  
 WHEN? \_\_\_\_\_ WAS ANYTHING INJURED?  YES  NO WHAT? \_\_\_\_\_  
 HOW WAS IT TREATED? \_\_\_\_\_  
 RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) \_\_\_\_\_  
 YES  NO WAS YOUR CHILD RIDING IN A "SAFETY BUCKET"? \_\_\_\_\_  
 WAS THE BUCKET IN THE  REAR SEAT OR  FRONT SEAT; FACING  FORWARD OR  BACKWARD? \_\_\_\_\_  
 YES  NO WAS YOUR CHILD IN A "BOOSTER SEAT"? \_\_\_\_\_  
 YES  NO DOES YOUR CAR HAVE AIRBAGS? \_\_\_\_\_  
 WAS YOUR VEHICLE STRUCK FROM THE  REAR  FRONT  LEFT SIDE OR  RIGHT SIDE? \_\_\_\_\_

HAS YOUR CHILD EVER HAD ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS OR SURGERYS?  
 FIRST: WHEN? \_\_\_\_\_ WHAT WAS INJURED? \_\_\_\_\_  
 HOW WAS IT TREATED? \_\_\_\_\_  
 RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) \_\_\_\_\_  
 SECOND: WHEN? \_\_\_\_\_ WHAT WAS INJURED? \_\_\_\_\_  
 HOW WAS IT TREATED? \_\_\_\_\_  
 RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) \_\_\_\_\_

HAS YOUR CHILD HAD X-RAYS? WHEN? \_\_\_\_\_ WHAT BODY PARTS? \_\_\_\_\_

**A** **FAMILY HEALTH HISTORY**

HEALTH STATUS (IF DECEASED, FROM WHAT?) \_\_\_\_\_  
 MOTHER: \_\_\_\_\_  
 FATHER: \_\_\_\_\_  
 SISTERS: \_\_\_\_\_ HOW MANY? \_\_\_\_\_  
 BROTHERS: \_\_\_\_\_ HOW MANY? \_\_\_\_\_

**LEVEL OF PAST MEDICAL, FAMILY, SOCIAL HISTORY (OFFICE USE ONLY)**  
 \_\_\_\_\_ N/A (01, 02, 11, 12, 13) \_\_\_\_\_ PERTINENT (03, 14) \_\_\_\_\_ COMPLETE (04, 05, 15)  
 (ONE OF THE ABOVE HISTORIES COMPLETED) (2 OR 3 OF THE ABOVE HISTORIES COMPLETED)

**A** **SYSTEM REVIEW QUESTIONS**

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES OR N FOR NO IN EACH OF THE FOLLOWING:)

1. _____ EYES	6. _____ URINARY	11. _____ INTERNAL ORGANS
2. _____ EARS, NOSE, MOUTH, THROAT	7. _____ MUSCLES	12. _____ BLOOD
3. _____ HEART	8. _____ NERVES	13. _____ ALLERGIES
4. _____ LUNGS/BREATHING	9. _____ SKIN	14. _____ OTHER _____
5. _____ INTESTINES	10. _____ PSYCHOLOGICAL	

PLEASE DESCRIBE: \_\_\_\_\_

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT IS SO APPROVED.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 D.C./C.A. SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**LEVEL OF SYSTEM REVIEW (OFFICE USE ONLY)**  
 \_\_\_\_\_ N/A (01, 11, 12) \_\_\_\_\_ EXTENDED (03, 14,) (2 TO 9 OF THE ABOVE SYSTEMS)  
 \_\_\_\_\_ PROBLEM PERTINENT (02, 13) (ONE OF THE ABOVE SYSTEMS) \_\_\_\_\_ COMPLETE (04, 05, 15) (10 OR MORE OF THE ABOVE SYSTEMS)

**LEVEL OF HISTORY (OFFICE USE ONLY)**  
 \_\_\_\_\_ PROBLEM FOCUSED (01, 12) \_\_\_\_\_ DETAILED (03, 14,)  
 \_\_\_\_\_ EXPANDED PROBLEM FOCUSED (02, 13) \_\_\_\_\_ COMPREHENSIVE (04, 05, 15)