PEDIATRIC HEALTH PROFILE

Child's Name _____Sex _____ Today's date_____

Parent/Guardian Contact Information:

Parent/Guardian_____Cell_____
Parent/Guardian_____Cell_____
Street Address _____
City_____ State_____ Zip_____
Home Phone (____)____-_____ Work (____)_____-_____
Primary Email _____Referred by _____

Child's Health History:
Date of Birth _____ Height_____Weight _____
Referred by_____
Reason for today's visit:
_____
Have other doctors been seen for this condition? Y/N ____
If yes, doctors' names and prior treatment _____

Check any of the following conditions from which your child has experienced during the past 6 months:

□Ear Infections	□Scoliosis	□Seizures	□ Chronic Colds	□Headaches
□Asthma/Allergies	□Digestive Problems	□ADD/ADHD	□ Recurring Fevers	□Colic
□Growing/Back Pains	□Bed Wetting	□Car Accident	□Temper Tantrums	□Other

Previous chiropractor_____
Date of last visit_____ Reason for visit _____
Name of pediatrician _____
Date of last visit _____ Reason for visit _____
Are you satisfied with the care your child has received there? Y/N _____

Number of Antibiotics your child has taken in:
Past 6 months _____ Total during his/her lifetime _____
Number of doses of other prescription medicines your child has taken in:
Past 6 months _____ Total during his/her lifetime _____

Immunization History:
If your child has had all of the recommended vaccines, indicate "ALL" _____
Have you opted out of any vaccines? If so, which ones _____
Have you split up any of the vaccine series? _____
Did you postpone or choose not to vaccinate? _____

(next)

Prenatal History:
Name of Obstetrician/Midwife

_____

Complications during pregnancy □No □Yes List: _____
Ultrasounds during pregnancy □No □Yes List: _____
Medications during pregnancy/delivery □No □Yes List: _____
Cigarette/Alcohol use during pregnancy □No □Yes

Location of birth: □Hospital □Birthing Center □Home
Birth intervention: □Forceps □Vacuum extraction □Cesarean □Emergency □Planned
Complications during delivery: □No □Yes List: _____
Birth weight_____ Birth Length _____ APGAR Scores _____

Feeding History:
Breast Fed: □No □Yes How long? _____Formula Fed: □No □Yes How long? _____
Introduced to solids at: _____ months Cow's milk at: _____ months
Food/juice allergies or intolerances: □No □Yes List: _____

Developmental History:
During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic. At what age was your child able to:
Respond to sound:_____Respond to visual stimuli: _____
Hold head up: _____ Sit up: _____
Cross Crawl: _____ Stand alone: _____
Walk alone: _____

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? □No □Yes

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? □No □Yes List: _____

Has your child ever been involved in a car accident? □No □Yes When? _____

Has your child been seen on an emergency basis? □No □Yes When/why?
_____

Other traumas not described above? □No □Yes List: _____
Prior surgery: □No □Yes List: _____
Menarche: □No □Yes Age: _____

We are here to serve you and we encourage you to ask questions. Your participation is vital and will help determine your results.