1004 Main St
Cedar Falls, IA
(319) 277-1868

Pediatric Health History Form

Child's Name: _____ Date of Birth: ___/___/____ Sex: M / F
Parent(s) Name(s): _____
Sibling's Name(s) and Age(s): _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Other Number: _____
Family doctor's name: _____
Who may we thank for referring you: _____
Has your child ever received chiropractic care?
If yes, who? _____
Date of last visit: _____
Reason for visit: _____
Other professions seen for this condition: _____
Results: _____
Any recent tests done (list date beside): Bloodwork _____Urine_____ X-Rays_____
Other: explain _____
Please tick the reason(s) for your child's visit:
▫crisis management ▫early detection of problems ▫prevention ▫wellness
▫ maximizing normal growth/development ▫other: _____

Authorizing Consent for examination of a Minor (under 18 years): Please Read Carefully

In order to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Radiance Chiropractic.

I have had the opportunity to discuss with Dr. Abby Welsh, 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 the child's interests.

Child's Name: _____ Date:_____
Parent Signature: _____ Witness: _____

Present Health Concerns

Major: _____

Minor: _____

When did this problem(s) begin?_____

Is this problem: occasional frequent constant intermittent (circle please)

What makes this worse?_____

What makes this better?_____

Is the problem worse during a certain time of day? Yes No

If yes, when?_____

Does this problem interfere with: *sleep?* Yes No *Eating?* Yes No *Daily Routine?* Yes No

Is this becoming worse? Yes No

Often, seemingly unrelated symptoms can manifest as other health concerns...Please tick if your child has had any of the following:

▫Headaches	▫Chest pressure	▫Weight loss
▫Dizziness	▫Breast pain	▫Weight gain
▫Irritability	▫Frequent colds	▫Dental problems
▫Fatigue	▫Sinus congestion	▫Fever
▫Depression	▫Sore throats	▫Heart palpitations
▫Loss of balance	▫Ear pain/infections	▫Numbness in feet
▫Loss of concentration	▫Asthma	▫Numbness in hands
▫Fainting	▫Cold sweats	▫Weakness
▫Ears buzzing	▫Bronchitis	▫Heartburn
▫Poor coordination	▫Pneumonia	▫Muscle cramps
▫Vision changes	▫Difficulty breathing	▫Upper back pain
▫Loss of memory	▫Shortness of breath	▫Neck pain
▫Loss of smell	▫Allergies	▫Low back pain
▫Loss of taste	▫Constipation	▫Radiating pain
▫Light sensitivity	▫Diarrhea	▫Sleeping problems
▫Face flushed	▫Urinary problems	▫Numbness in legs
▫Reduced mobility	▫Bloating/gas	▫Stiffness

Other: _____

Birth History

What was the child's gestational age at birth? _____ weeks.
Birth weight _____lbs _____oz Birth Length _____ inches
Was your child's birth: At home Birthing center Hospital Other (circle)
Was the birth considered: Medical Midwife Duration of birth: _____hours
Was child born: Cephalic(head first) Breech (feet first)
Were there any complications? Yes No If yes, please explain:_____
Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy
Was labour: Spontaneous Induced
Were medications or epidurals given to the mother during birth? Yes No
APGAR score: at birth_____/10 After 5 minutes _____/10
Is there anything else we need to know about the birth? Please explain: _____
_____

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No
If no, please explain: _____

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe_____
Crawl _____ Walk _____

Does your child sleep: Front / Back / Side
Do you consider the sleeping pattern normal? Yes No How many hours per day?_____
If no, please explain:_____

Family Health History

Please list any health concerns (ie. cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mother's family:_____
Father's family:_____
Siblings: _____

Physical Stressors

Any traumas to the mother during pregnancy? (ie, falls, accidents) Yes No
If yes, please explain: _____
Any evidence of birth trauma to the infant?

- ▫ bruising
- ▫stuck in birth canal
- ▫respiratory depression
- ▫odd shaped head
- ▫fast or excessively long birth
- ▫cord around neck

Any falls from couches, beds, change tables, etc? Yes No
If yes, please explain: _____
Any traumas resulting in bruises, cuts, stitches or fractures? Yes No
If yes, please explain: _____
Any hospitalizations or surgeries? Yes No
If yes, please explain: _____
Any sports played? _____
Is a school backpack used? Yes No *Is it* Heavy / Light

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long?_____
Formula introduced at what age: _____ Which formula? _____
Introduction of cow's milk at what age: _____ Solid foods at what age: _____
Types of solid foods: _____
Food/Juice intolerance? Yes No Type: _____
Is your child on/previously on any medications? Yes No
If yes, which ones and for how long? _____

During mother's pregnancy:
Did mother smoke? Yes No How much?_____
Drink alcohol? Yes No How much? _____
Any illnesses during pregnancy? Yes No If yes, describe: _____
Any supplements taken during pregnancy? Yes No If yes, describe: _____
Any drugs taken during pregnancy? Yes No If yes, describe: _____
Any ultrasounds? Yes No How many: _____

Reasons for being done: _____

Any invasive procedures during pregnancy? (ie. amniocentesis, chorionic villi sampling)? Yes No
If yes, please explain: _____
_____

Any pets at home? Yes No
Any smokers in the home? Yes No
Any antibiotics given? Yes No If yes, reason: _____
Is the diet organic? Yes No
Do you use "green products" in your home for cleaning? Yes No
How often do they receive processed foods, white sugar, gluten (flour), dairy in the diet?

▫ Never ▫Weekends ▫Few times per week
▫Daily ▫Nearly each meal ▫Special occasions

Psychosocial Stressors

Any difficulties with lactation? Yes No
Any problems with bonding? Yes No
Any behavioral problems? Yes No
Any inattention? Yes No
Any hyperactivity or restlessness? Yes No
Any compulsiveness? Yes No
Any difficulties at daycare or school? Yes No
Any night terrors, sleep walking, difficulty sleeping? Yes No
Any prolonged temper tantrums or separation anxiety? Yes No
Is the child in daycare? Yes No
Age of child when they began daycare? _____
Is there a nanny or regular sitter during the day if both parents work? Yes No
Is the child home schooled? Yes No By Whom? _____
Average number of hours of TV per week? _____
Average number of hours of video games per week?_____
Does your child have a cell phone? Yes No
Do you feel your child's social/emotional development is normal for their age? Yes No

Thank you for completing this form. If you have anything to add, please add notes which can then be discussed with the doctor. If there are any other questions or concerns that you have, please discuss with us.