904 Rainbow Dr
Cedar Falls, IA 50613
(319)-277-1868

Pediatric Health History Form

Child's Name: ______________________ DOB: ___/___/____ Sex: ☐ M ☐ F
Parent(s) Name(s): ____
Sibling's Name(s) & Age(s): ____
Address: _______________________ City: ____________ ZIP: ____________
Cell #: (____)____-________ Other #: (____)____-________
Family Care Physician: ____
Who can we thank for referring you: ___________________________________

Has your child ever received chiropractic care? ☐ Yes ☐ No
If yes, who: _______________________ Date of last visit: _________________
Reason for visit: ____

Reason(s) for your child's visit today:
☐ Prevention/early detection of future problems
☐ 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: ______________________________ Date: ___/___/____

Current Health Concerns

Health Concern #1: ____

When did symptom(s) start: ____

Are symptoms: ☐ Constant ☐ Frequent ☐ Occasional

Since symptoms began, are they: ☐ Getting worse ☐ Getting better ☐ About the same

What makes it worse? ____

What makes it better? ____

Other providers seen for current conditions: ______________________________

Any tests done recently? ☐ Bloodwork ☐ Urine ☐ X-rays Other:_______________

Results: ____

Health Concern #2: ____

When did symptom(s) start: ____

Are symptoms: ☐ Constant ☐ Frequent ☐ Occasional

Since symptoms began, are they: ☐ Getting worse ☐ Getting better ☐ About the same

What makes it worse? ____

What makes it better? ____

Other providers seen for current conditions: ______________________________

Any tests done recently? ☐ Bloodwork ☐ Urine ☐ X-rays Other:_______________

Results: ____

Health Concern #3: ____

When did symptom(s) start: ____

Are symptoms: ☐ Constant ☐ Frequent ☐ Occasional

Since symptoms began, are they: ☐ Getting worse ☐ Getting better ☐ About the same

What makes it worse? ____

What makes it better? ____

Other providers seen for current conditions: ______________________________

Any tests done recently? ☐ Bloodwork ☐ Urine ☐ X-rays Other:_______________

Results: ____

Health Concern #4: ____

When did symptom(s) start: ____

Are symptoms: ☐ Constant ☐ Frequent ☐ Occasional

Since symptoms began, are they: ☐ Getting worse ☐ Getting better ☐ About the same

What makes it worse? ____

What makes it better? ____

Other providers seen for current conditions: ________________________________

Any tests done recently? ☐ Bloodwork ☐ Urine ☐ X-rays Other:________________

Results: ____

Health Concern #5: ____

When did symptom(s) start: ____

Are symptoms: ☐ Constant ☐ Frequent ☐ Occasional

Since symptoms began, are they: ☐ Getting worse ☐ Getting better ☐ About the same

What makes it worse? ____

What makes it better? ____

Other providers seen for current conditions: ________________________________

Any tests done recently? ☐ Bloodwork ☐ Urine ☐ X-rays Other:________________

Results: ____

Please check any of the following health conditions that your child has suffered from:

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

Other: ____

Birth History

What was gestational age at birth? ____ weeks

Birth took place at: ☐ Home ☐ Birthing center ☐ Hospital Other: __________

Birth provider: ☐ Midwife ☐ OBGYN Duration of birth: ______ hours

Child was born: ☐ Head first/Cephalic ☐ Feet first/Breech

Any birth complications? ☐ Yes ☐ No If yes, explain:_________________________

Assistance during birth: ☐ Forceps ☐ Vacuum ☐ Episiotomy ☐ C-section

Labor began: ☐ Spontaneously ☐ Induction

Medications (ie. epidural, pitocin, oxytocin) during labor/birth: ☐ Yes ☐ No

If yes, what: ____

Anything else we should know about birth: ______________________________________

Growth and Development

Place an X by all of the developmental skills your child can do:

Age 0-1	**X**	**Age 1-2**	**X**	**Age 3+**	**X**
Bring hands to mouth		Say simple words like “mama” “dada” “no” “bye”		Walk up and down stairs independently	
Grasp and shake toys		Walk without holding onto things		Use a cup, fork, and spoon to feed themselves	
Make babbling noises		Use simple phrases		Expresses like and dislikes	
Turn head towards sound		Follow simple instructions		Use zippers, snaps and buttons on clothing	
Use pincer grip with both hands		Use both hands to play with toys		Hop, skip, and jump	
Respond to “no”		Run		Say complete sentences	
Sit up unassisted		Kick a ball		Is potty trained	
Crawl on all fours - opposite hand with opposite leg		Walks with normal pattern (ie. not walking on tip toes)		Expresses a range of emotions	

Please list any developmental difficulties/concerns and explain:

____

Physical Stressors

Any traumas or major injuries to the mother during pregnancy? ☐ Yes ☐ No

If yes, explain: ____

Any evidence of birth trauma to the infant:

☐ Bruising ☐ Misshapen head
☐ Stuck in birth canal ☐ Fast or excessively long birth
☐ Respiratory depression ☐ Cord around neck

Any falls from couches, beds, change tables, etc.? ☐ Yes ☐ No

If yes, explain: ____

Any traumas resulting in major bruising, major cuts, stitches, or fractures? ☐ Yes ☐ No

If yes, explain: ____

Any hospitalizations or surgeries? ☐ Yes ☐ No

If yes, explain: ____

Any sports played? ____

Chemical Stressors

Was the child breastfed? ☐ Yes ☐ No If yes, how long? __________________

Was formula introduced? ☐ Yes ☐ No At what age and brand? ______________

What age was cow's milk introduced? ______

What age did the child start solid foods: ______ Types of solids: ______________

Food/Juice intolerance or allergies? ☐ Yes ☐ No Please list: ________________

Is your child currently taking medications? ☐ Yes ☐ No

If yes, which ones and how long? ______________________________________

Has your child taken any medications in the past? ☐ Yes ☐ No

If yes, which ones and how long? ______________________________________

During pregnancy did mother:

Smoke? ☐ Yes ☐ No How much: ____________

Drink alcohol? ☐ Yes ☐ No How much: ____________

Have any major illnesses? ☐ Yes ☐ No If yes, list: ______________________

Take any supplements, medications or drugs? ☐ Yes ☐ No Please list: __________

Were there ultrasounds done during pregnancy? ☐ Yes ☐ No How many: _______

Any invasive procedures done during pregnancy? (ie. amniocentesis, chorionic villi sampling, etc.) ☐ Yes ☐ No If yes, explain: ____________________________________

Are there any pets in the home? ☐ Yes ☐ No List type of pet: __________________

Are there any smokers in the home? ☐ Yes ☐ No

Has the child ever taken any antibiotics? ☐ Yes ☐ No

If yes, for what and how many times: ____

Please mark the following foods that are regularly consumed by your child:

☐ Fruits ☐ Vegetables ☐ Whole grains ☐ Meat ☐ Dairy ☐ Fast food

Do you buy mostly organic foods? ☐ Yes ☐ No

How often does your child eat processed foods like white sugar, gluten(flour), and dairy? ☐ Never ☐ Occasionally ☐ Few times a week ☐ Daily ☐ Most meals

Psychosocial Stressors

Any difficulties with breastfeeding? ☐ Yes ☐ No

Any problems bonding? ☐ Yes ☐ No

Any behavior problems? ☐ Yes ☐ No

Any difficulties with attention? ☐ 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, or difficulties sleeping? ☐ Yes ☐ No

Any prolonged temper tantrums or separation anxiety? ☐ Yes ☐ No

Is the child in daycare currently? ☐ Yes ☐ No

Do they have a nanny or regular babysitter during the day? ☐ Yes ☐ No

Is the child home schooled? ☐ Yes ☐ No

Do you feel your child's social/emotional development is normal for their age?

☐ Yes ☐ No If no, explain: ____

Average amount of screen time every day: _______

Thank you for completing this form. If you feel that there is anything else that needs to be addressed, please add notes about it. If you have any other questions or concerns, please discuss them with us.