File #_____

TREE OF LIFE CHIROPRACTIC

Pediatric Health History form: Today's Date_____

Child's Full name: _____ Goes by: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Partner's Name: _____

Mother's Phone #: _____ Partner's Phone #: _____

Email: _____

Would you like to be signed up for reminders (circle one)? EMAIL TEXT NEITHER

- if text who is your cell phone provider_____

Child's Birth Date: _____ Male/Female (circle one)

Reason for consulting our office?: _____

Whom may we thank for referring you?: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

May we contact them (circle one): YES NO

Health Profile:

Primary Goal for your kiddos care? _____

Secondary Goal for your kiddos care? _____

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals at first are:

1. Addressing the issues that brought you into this office
2. Helping your child heal and maintain a healthy spine and nervous system

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐

If you came in today for a specific complaint, please fill out the next portion briefly describing it:

If he/she is experiencing pain, is it (check all that apply):

☐ Sharp ☐ Shooting

☐ Burning ☐ Aching

☐ Dull ☐ Burning

☐ Comes and Goes ☐ Constant

☐ Travels ☐ Worse with movement

Since the problem started is it:

☐ Same ☐ Better ☐ Getting Worse

What makes it worse? _____

What does it interfere with? _____

Who else have you seen for the issue? _____

- Has it helped? _____

List medications the child is currently taking:

_____

_____

_____

Past surgeries, traumas or accidents:

_____

_____

Number of doses of antibiotics the child has taken:

_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Was IVF needed? Explain: _____

Third trimester presentation: ☐ Head down ☐ Breech ☐ Transverse ☐ Face/Brow

Were there any complications to the pregnancy? _____

Was Mom on any medications (prescription or over the counter)? _____

- If yes, please explain: _____

Did Mom or Dad ever smoke during pregnancy? Yes/No (circle one) Who? _____

How many ultrasounds were performed? _____

Birth and Delivery:

Where was the baby born? ☐ Home ☐ Hospital ☐ Birthing center

☐ Other: _____ ☐ Transfer?

Was the delivery: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum/ Suction Cap

How long was labor? _____ How long was the delivery? _____

Was oxytocin/Pitocin used? Yes/No (Circle one)

Was an epidural used? Yes/No (Circle one) Apgar Scores: _____

Birth Weight _____ Length: _____

Congenital anomalies/Defects?_____

Were regular Well Baby Checks performed? _____ Where? _____

May we Contact them? _____

Check any box that applies **currently** *or* in the **past**:

- ☐ Seizures
- ☐ Ear/Sinus infection
- ☐ Asthma
- ☐ Allergies & congestion
- ☐ Failure to thrive
- ☐ Colic/Excessive crying
- ☐ Immune deficiency
- ☐ Headaches/migraines
- ☐ Vision/hearing issues
- ☐ Low energy & Fatigue
- ☐ Sensory/Spectrum
- ☐ ADD/ADHD
- ☐ Focus/Memory issues
- ☐ Anxiety/ Stress
- ☐ Speech issues
- ☐ Depression
- ☐ Reflux/GERD
- ☐ Chronic cough/colds
- ☐ Diabetes Mellitus type ____
- ☐ Bronchitis/Pneumonia
- ☐ Jaundice
- ☐ Eczema
- ☐ Food allergies
- ☐ Bedwetting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Lower Back pain
- ☐ Kidney issues
- ☐ Knock Knee
- ☐ Scoliosis

Check Met or Not Met; if delayed please specify by how much:

Age	Milestone	Met	Not Met	Delayed
1 Month	Fists clench			
2 Months	Smiles			
	Coos			
	Hands open			
3 Months	Head Control			
	Opens Mouth			
4 Months	Laughs			
	Push Up			
5 Months	Back→stomach			
6 Month	Sits alone in tripod			
	Reaches			
	1 Syll word "da"			
8 Months	Sits alone			
	Pincher grip			
	2 syll word "dada"			
10 Months	Pulls up to stand			
	Points			
11 months	Cruising			
12 Months	Stands alone			
	Walks w/support			
	Holds cup			
	Knows 2 words			
15 months	Walks alone			
	Crawls upstairs			
	Names objects			
	Marks with pencil			
	Says 4-5 words			
	Indicates wants			
18 Months	Runs			
	Points to body parts			
	Partially feeds self			

Infancy (Under 1 years old):

Was the infant vaccinated? Yes/No (Circle one) If Yes, List them with dates:

_____

_____

Infant feeding: ☐ Breast ☐ Formula, Which? _____

Number of hours sleeping per night? _____

Quality of Sleep? ☐ good ☐ fair ☐ poor

Was there any prolonged use of medications or an inhaler? Yes/No (Circle one)

- If yes, Explain: _____

Did the infant suffer any traumas such as serious falls or car accidents?

Yes/No (Circle one) If yes, Explain: _____

Has the infant ever been under regular chiropractic care? Yes/No (Circle one)

Did the child have any childhood illnesses? Yes/No (Circle one)

- If yes, Explain: _____

Does the child play any youth sports? Yes/No (Circle one)

- If yes, which one(s)? _____

Has the child suffered from emotional traumas? Yes/No (Circle one)

What kinds of hobbies/activities does your kiddo love? _____

How much screen time does your kiddo get/day? _____

Please give us any other health information you feel would be helpful:

_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to Tree of Life Chiropractic to examine and care for my child.

Guardian's Signature: _____

Relationship to child? : _____ Date signed: _____