

ROCK SPRINGS FAMILY CHIROPRACTIC PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name _____ Today's Date ____/____/____ PtID#: _____

Date of Birth ____/____/____ Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

Who is responsible for this bill? Father Social Security # _____ - _____ - _____ Mother Social Security # _____ - _____ - _____

Other (please explain): _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness Check-up _____ Injury or Accident _____ Other Please explain: _____

If your child is experiencing **pain/discomfort please identify where** _____ **and for how long** _____

1. **When did the problem first begin?** Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden _____
2. **Ever had this problem before?** No Yes If yes when? _____
3. **Any bowel or bladder problems since this problem began?** No Yes (Describe) _____
4. **Have you seen any other doctors for this problem?** No Yes If yes, who? _____
5. **How long ago?** _____ Days _____ Weeks _____ Months _____ Years _____
6. **What were the results of past treatment?** _____
7. **How is this problem NOW:** Rapidly Improving Slowly Improving About the Same Gradually Worsening On & Off
8. **Please list any medication taken for this problem:** _____
9. **Has your child ever sustained an injury playing sports?** _____ If yes, please explain _____
10. **Has your child ever sustained an injury in an auto accident?** _____ if yes, please explain _____

HAS YOUR CHILD EVER SUFFERED FROM: mark a Y for YES OR N for NO

___ Headaches	___ Orthopedic Problems	___ Digestive Disorders	___ Behavioral Problems	___ Fall From Changing Table
___ Neck Problems	___ Poor Appetite	___ ADD/ADHD	___ Fainting	___ Fall Off Skateboard/Skates
___ Stomach Aches	___ Ruptures/Hernia	___ Seizures/Convulsions	___ Leg Problems	___ Fall From Bed or Couch
___ Muscle Pain	___ Heart Trouble	___ Joint Problems	___ Constipation	___ Fall Off Monkey Bars
___ Chronic Earaches	___ Backaches	___ Diarrhea	___ Sinus Trouble	___ Fall From High Chair
___ Hypertension	___ Asthma	___ Scoliosis	___ Anemia	___ Arm Problems
___ Walking Trouble	___ Bed Wetting	___ Colic	___ Broken Bones	___ Dizziness
___ Fall In Baby Walker	___ Fall From Crib	___ Fall Off Swing	___ Fall Off Bicycle	___ Growing Pains
___ Fall Downstairs	___ Fall Off Slide	___ Sleeping Problems	___ Colds/Flu	___ Poor Posture
___ Reflux	___ Allergies to _____	___ Other: _____		

I understand that I am directly and fully responsible to Trinity Chiropractic for all fees associated with chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that the actual films are the sole legal property of Trinity Chiropractic and that by law, the doctor must retain these films for a period of no less than 7 years.

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request, and authorize imaging studies, and chiropractic adjustments, for the benefit of my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date

Functional Questionnaire

Patient Name: _____

Date: _____

Daily Activities: Effects of Current conditions On Performance

Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

CHEMICAL STRESSORS

Was this child breast-fed? **YES NO** If YES, how long? _____

Formula introduced at what age? _____ What formula _____

Introduction of cow's milk at what age? _____ Began solid foods at what age? _____

Food/Juice intolerance? **YES NO** Type? _____

During pregnancy did the mother smoke? **YES NO** How much? _____

drink? **YES NO** How much? _____

Any illnesses during pregnancy? **YES NO**

Any supplements taken during pregnancy? **YES NO**

Any drugs taken during pregnancy? **YES NO**

Any ultrasounds? **YES NO** How many? _____

Any invasive procedures during pregnancy (i.e. amniocentesis etc.) **YES NO**

If YES, please explain _____

Any pets at home? **YES NO**

Any smokers at home? **YES NO**

Vaccination History

Vaccinations and age given _____

Any negative reactions? **YES NO**

If YES, please explain _____

Any antibiotics given? **YES NO**

If YES, please give name _____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? **YES NO**

Any problems with bonding? **YES NO**

Any behavioral problems? **YES NO**

Any night terrors, sleep walking, difficulty sleeping? **YES NO**

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel your child's social and emotional development is normal for their age? **YES NO**

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

HISTORY OF BIRTH

What was the child's gestational age at birth? _____ weeks.
Birth weight _____ lbs _____ oz Birth length _____ inches.

Was your child born (circle) *at home* *in a birthing center* *in a hospital*
Was your birth assisted by *medical* *midwife*

What was the duration of the labor and birth? _____ hours.

Was the child born (circle) *cephalic (head first)* *breech (feet first)*

Were there any complications? *YES* *NO*

If YES, please explain _____

Please circle any assistance which was used at birth

Forceps *Vacuum extraction* *C-section* *Episiotomy*

Was labor (circle) *spontaneous* *induced*

Were medications or epidurals given to the mother during birth? *YES* *NO*

If YES, what was given _____

APGAR score: at Birth _____ /10 After 5 minutes _____ /10

FAMILY HEALTH HISTORY

Please note any health problems (i.e. Cancer, hereditary conditions, diabetes, heart disease etc.)

Mother's family _____

Father's family _____

Siblings _____

Since problems that Chiropractors look for and can detect can be related to many types of stressors, the following information is also very important to us.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (I.e. Falls, accidents, etc.) *YES* *NO*

If YES, please explain _____

Any evidence of birth trauma to the infant? (please check)

___ bruising ___ odd shaped 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, 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* or *LIGHT* (circle)

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

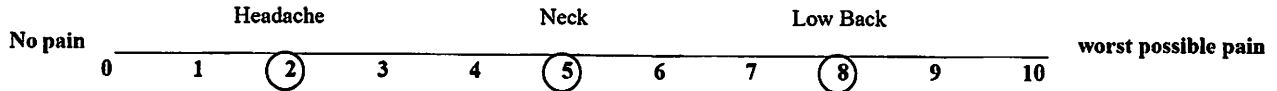
Date _____

Please read carefully:

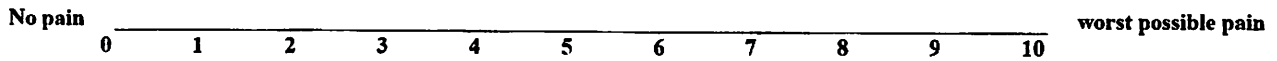
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

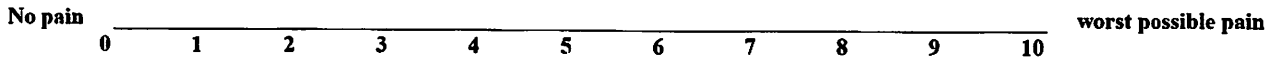
Example:



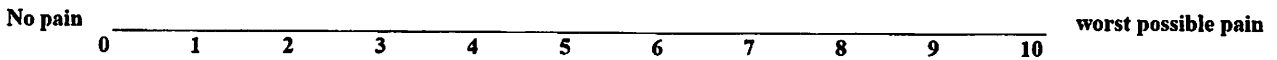
1 – What is your pain RIGHT NOW?



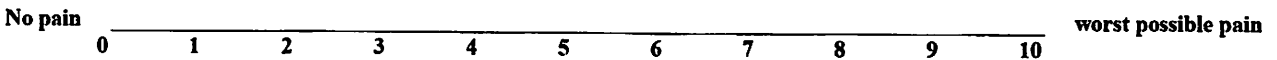
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF. Back pain in primary care: Outcomes at 1 year. 855-862, 1993, with permission from Elsevier Science.