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	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ 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:

	Headache			Neck			Low Back				
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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.