**Rock Springs Family Chiropractic Pediatric History Form**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have Insurance: 🞏 Yes 🞏 No

Pediatrician/Family MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit \_\_\_ /\_\_\_ /\_\_\_

Parent’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of siblings and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(🞏 I’ve never been to a chiropractor)*

*Who can we thank for referring you to our office?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the problem first begin? Date \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ \_\_\_\_\_Unknown \_\_\_\_\_Gradual \_\_\_\_\_Sudden

Was this problem a result of any type of accident? *YES NO Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Have they ever had this problem before?  No  Yes If yes when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any bowel or bladder problems since this problem began? *YES NO* (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other doctors for this problem? *YES NO* If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago? \_\_\_\_\_\_\_\_Days \_\_\_\_\_\_\_\_ Weeks \_\_\_\_\_\_\_\_\_ Months \_\_\_\_\_\_\_\_Years

What were the results of past treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is this problem NOW:  Rapidly Improving  Slowly Improving  About the Same  Gradually Worsening  On & Off

**Please mark P** for in the **Past, C** for **Currently** haveand **N** for **Never**

\_\_\_ Headache \_\_\_ Neck Pain \_\_\_ Back Aches \_\_\_ Orthopedic Problems \_\_\_ Muscle Pain

\_\_\_ Dizziness \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Fainting \_\_\_ Seizures

\_\_\_ Poor Appetite \_\_\_ Convulsions/Epilepsy \_\_\_ Diarrhea \_\_\_ Constipation \_\_\_ Digestive Disorders/Stomach Ache

\_\_\_ Joint Problems \_\_\_ Arm Problems \_\_\_ Leg Problems \_\_\_ Bed Wetting \_\_\_ Behavioral Problems

\_\_\_ Asthma \_\_\_ ADD/ADHD \_\_\_ Vision Issues \_\_\_ Ear Ache/Infections \_\_\_ Frequent Sickness (cold/flu)

\_\_\_ Relux \_\_\_ Colic \_\_\_ Sinus Trouble \_\_\_ Depression/Anxiety \_\_\_ Broken Bones/Fracture

\_\_\_ Scoliosis \_\_\_ Poor Posture \_\_\_ Diabetes \_\_\_ Sleeping Problems \_\_\_ Learning Disability

\_\_\_ Hypertension \_\_\_ Skin Problems/Eczema \_\_\_ Heart condition \_\_\_ Allergies (To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

\_\_\_Cancer (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) **\_\_\_** Other conditions/diagnoses not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

Please circle the number that best describes the question being asked. If your child has more than one complaint/condition listed above, indicate the score for each one using the shapes provided. **See example below:**

*(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)*

*(****Example****: Headache Shoulder pain Colic)*

Primary Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is their discomfort RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

What is their TYPICAL or AVERAGE discomfort?

0 1 2 3 4 5 6 7 8 9 10

What is their discomfort level AT ITS BEST (How close to “0” does the condition get at its best)?

0 1 2 3 4 5 6 7 8 9 10

What is their discomfort level AT ITS WORST (How close to “10” does the condition get at it’s worst)?

0 1 2 3 4 5 6 7 8 9 10

**DAILY ACTIVITIES:** Please identify how your child’s condition is affecting their ability to carry out daily activities of life:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bending | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Concentrating | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Doing computer Work | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Playing Sports | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Recreation Activities | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Sleeping | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Watching TV | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Dressing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Lifting | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Pushing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Rolling Over | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Sitting | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Standing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Climbing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Doing Chores | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Reading | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Running | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Sitting to Standing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Walking | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |

I understand that I am directly and fully responsible to Rock Springs Family 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 legalproperty of Rock Springs Family 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 Completed Doctor’s Signature Date Reviewed**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**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 one) *at home in a birthing center in a hospital*

Was the birth considered (circle one) *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

**Since problems that Chiropractors look for and detect can be related to many types of stressors,**

**the following information is 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 (circle): *couch bed/crib changing table high chair bicycle slide downstairs*

*Others not listed, 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever sustained an injury playing sports? *YES NO*

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever sustained an injury in an auto accident? *YES NO*

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is a school backpack used? *YES NO Is it HEAVY or LIGHT (circle)*

**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?\_\_\_\_\_\_\_\_\_\_\_\_

During pregnancy did the mother drink? *YES NO* How much?\_\_\_\_\_\_\_\_\_\_\_\_

Any illnesses during pregnancy? *YES NO*

Any supplements taken during pregnancy? *YES NO* Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any drugs taken during pregnancy? *YES NO* Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*

Vaccinations and age given\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any negative reactions (including “mild” reactions)? *YES NO*

If YES, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any antibiotics given? *YES NO*

If YES, please give name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Prescription & Non-Prescription drugs or supplements your child takes**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 that you have, write them in the space below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*We are here to help you and your family reach your God-given potential, in Health and in Life!!*

*We look forward to helping you reach your health goals!*