

Pediatric Health History

In order to provide you the best wellness care, please complete this form in its entirety. All information is strictly **CONFIDENTIAL**.



PATIENT INFORMATION

TODAY'S DATE	NAME	<input type="radio"/> Male <input type="radio"/> Female	AGE	BIRTH DATE
ADDRESS			CITY	
STATE	ZIP CODE	HOME PHONE	CELL PHONE	
EMAIL ADDRESS <i>*Your email will not be shared with any 3rd parties, and is used for occasional office announcements and promotions.</i>				
PRIMARY PHYSICIAN/PEDIATRICIAN	OFFICE PHONE NUMBER	If your doctor did NOT refer you to our clinic, can we send a summary of this visit to your doctor? <input type="radio"/> Yes <input type="radio"/> No		
Whom may we thank for referring you to our office today?		Would you like to Opt In for Text Message Appointment Reminders? <input type="radio"/> Yes <input type="radio"/> No		






FAMILY INFORMATION

MOTHER'S NAME	PRIMARY/HOME PHONE	SECONDARY WORK/CELL PHONE
FATHER'S NAME	PRIMARY/HOME PHONE	SECONDARY WORK/CELL PHONE
PARENT'S MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed		Does one or both parents have custody? <input type="radio"/> Both <input type="radio"/> Mother <input type="radio"/> Father
NAMES & AGES OF OTHER CHILDREN IN THE FAMILY:		

EMERGENCY CONTACT INFORMATION

IN AN EMERGENCY CONTACT:	RELATIONSHIP	
HOME PHONE	WORK PHONE	CELL PHONE

ACCOUNT INFORMATION

NAME OF PARTY RESPONSIBLE FOR PAYMENT	RELATIONSHIP		
BILLING ADDRESS	CITY		
STATE	ZIP CODE	HOME PHONE	DRIVERS LICENSE #
SOCIAL SECURITY #	PAYMENT METHOD <input type="radio"/> Cash <input type="radio"/> Check <input type="radio"/> Credit Card <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 		
CREDIT CARD NUMBER	EXPIRATION DATE	CCV CODE	

I understand that outstanding balances of more than 30 days will be charged to this account.

CARD HOLDER'S SIGNATURE _____

DATE _____

CONSENT TO EVALUATE & TREAT A MINOR

I, being the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request Donohoe Chiropractic and/or Doctor(s) of this clinic to administer such treatment deemed advisable, including but not limited to examinations, radiological exams, and/or treatment. I agree that I will be responsible for any bill incurred on behalf of the above named individual.

A photocopy of this form associated signature(s) shall be considered as effective and valid as the original.

PARENT/GUARDIAN'S SIGNATURE _____

DATE _____

TYPE OF CARE DESIRED

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- RELIEF
 CORRECTION OF THE CAUSE
 PREVENTION
 LET THE DOCTOR DECIDE

LEARNING, DEVELOPMENTAL & SCHOOL

CHILD'S CURRENT GRADE LEVEL

NUMBER OF SCHOOLS ATTENDED

Is your child home-schooled? Yes No
 Does your child enjoy school? Yes No

SPECIFIC LEARNING DISABILITIES

ACADEMIC STRENGTHS

HOW IS YOUR CHILD DOING IN SCHOOL?

DRUG/ALCOHOL HISTORY

NUTRITION HISTORY *Please describe a typical day's diet for your child:*

BREAKFAST

LUNCH

DINNER

SNACKS

FAVORITE FOODS

ARE THERE ANY FOODS THAT YOUR CHILD "LOVES" OR "CRAVES"?

How many cups of the following does your child drink?

WATER

JUICE

SODA

COW'S MILK

OTHER DRINKS

IMMUNIZATIONS & ANTIBIOTICS

Is your child fully immunized? Yes No

If not, please check the vaccines your child has had:

- MMR** (*Measles Mumps Rubella*)
 Hib (*Haemophilus*)
 Varicella (*Chicken Pox*)
 DTaP (*Diphtheria Tetanus Pertussis*)
 IPV (*Polio*)
 Hepatitis A
 Hepatitis B
 Influenza
 HPV (*Cervical Cancer*)
 Meningococcus (*Meningitis*)
 Others

Do you think there was any relation between timing of the vaccines and development of any of the health concerns you may have?
 Yes No *(If yes, please explain)*

Approximately how many antibiotics has your child had (total life)?

How many antibiotics did your child receive in one year (worst year)?

MEDICATIONS & SUPPLEMENTS

CURRENT PRESCRIPTION MEDICATIONS:

CURRENT VITAMINS, HERBS & SUPPLEMENTS:

MEDICATIONS YOUR CHILD IS ALLERGIC TO:

SLEEP HABITS

How many hours per night does your child sleep?

Naps (number & length)

Trouble falling asleep? Yes No

Trouble staying asleep? Yes No

Any sleep problems? Yes No *(If yes, please explain)*

Sleep Behaviors *(Please check all that apply)*
 Sleepwalking
 Nightmares
 Recurrent Dreams

BIRTH & INFANT HISTORY

MEDICATIONS DURING PREGNANCY

Did you have gestational diabetes? Yes No

Did you require antibiotics prior or during delivery? Yes No

Were you induced? Yes No

GESTATION PERIOD (IN WEEKS):

DURATION OF LABOR (IN HOURS):

TYPE OF BIRTH

Vaginal **C-Section**

DURATION OF BIRTH (IN HOURS):

APGAR SCORE

BIRTH WEIGHT

Assistance during birthing?
 Vacuum
 Forceps

Was your child:
 Breech
 Side Lying

COMPLICATIONS DURING BIRTH

BIRTH INJURIES

Did your child have any of the following problems shortly after birth?
 Birth Injuries
 Blue Baby
 Cerebral Palsy
 Seizures
 Jaundice
 Other *(Please explain)*

BIRTH & INFANT HISTORY (CONT.)

Did your child have: COLIC? Yes No
REFLUX? None Mild Moderate Severe
POSSIBLE MILK OR SOY ALLERGY AS AN INFANT? Yes No

Was your child breast fed? Yes No For how long?

Was your child fed formula? Yes No What type? Milk Soy Other:

HEALTH INFORMATION

PURPOSE OF THIS APPOINTMENT

When did this condition begin?

Other Doctor(s) seen for this condition? Yes No *If yes, who?*

TYPE OF TREATMENT(S):

RESULTS:

MEDICATION(S):

MAJOR SURGERIES/OPERATIONS:

MAJOR ACCIDENTS OR FALLS:

Previous Chiropractic Care? Yes No

DOES YOUR CHILD SUFFER FROM: *(Please check all that apply)*

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies <i>(please list)</i>
_____ | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bladder Trouble
<i>(bed wetting, infection)</i> | <input type="checkbox"/> Ear aches/Infections | <input type="checkbox"/> Pain <i>(Please describe)</i>
_____ |
| <input type="checkbox"/> Chest Congestion/Coughs | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Walking/Movement Problems
<i>(Please describe)</i>
_____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Headaches <i>(How often?)</i>
_____ | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Disease | |