BACK IN ACTION CHIROPRACTIC

# PEDIATRIC (AGES 5-11) HEALTH RECORD

NAME: _____ PARENT'S HOME PHONE: _____

STREET ADDRESS / P.O. BOX _____ PARENT'S MOBILE PHONE: _____

CITY / STATE / ZIP: _____ PARENT'S WORK PHONE: _____

SOCIAL SECURITY NUMBER: _____ CHILD'S BIRTHDATE: _____

MOM'S NAME: _____ INSURED'S EMPLOYER: _____

DAD'S NAME: _____ FAMILY EMAIL: _____

NAMES / AGES OF OTHER CHILDREN AT HOME: _____

WHO IS THEIR FAMILY MEDICAL DOCTOR? _____ FACILITY / CITY: _____

HOW WERE YOU REFERRED? ☐MY M.D. ☐INS. PLAN ☐ANOTHER PERSON: _____ OTHER: _____

## PATIENT DEMOGRAPHICS

(*REQUIRED PER FEDERAL GUIDELINES)

***GENDER:** ☐MALE ☐FEMALE ☐OTHER: _____ ***ETHNICITY:** ☐HISPANIC ☐NOT HISPANIC

***RACE (SELECT ONE):** ☐WHITE/CAUCASIAN ☐BLACK/AFRICAN AMERICAN ☐AMERICAN INDIAN ☐ASIAN
☐OTHER: _____

***PREFERRED LANGUAGE:** ☐ENGLISH ☐SPANISH ☐RUSSIAN ☐POLISH ☐CHINESE ☐OTHER: _____

***DRUG ALLERGIES:** ☐NONE **-OR-** ☐ LIST: _____

| ***CURRENT PRESCRIPTION MEDICATIONS** *NAME OF PRESCRIPTION (BRAND OR GENERIC)* | **DOSE** *(MG, ML, ETC.* | **FORM** *(TAB, CAPS, INJ., ETC.)* | **FREQUENCY** *(# PER DAY/WEEK/MO.)* |
|---|---|---|---|
| | | | ____ X PER ____ |
| | | | ____ X PER ____ |
| | | | ____ X PER ____ |
| | | | ____ X PER ____ |
| | | | ____ X PER ____ |

| ***CURRENT VITAMINS/SUPPLEMENTS** *BRAND & TYPE* | **DOSE** *(MG, ML, ETC.* | **FORM** *(TAB, CAPS, POWDER, ETC.)* | **FREQUENCY** *(# PER DAY/WEEK/MO.)* |
|---|---|---|---|
| | | | ____ X PER ____ |
| | | | ____ X PER ____ |
| | | | ____ X PER ____ |

**OFFICE USE ONLY:**

**Height:** _____ inches; **Weight:** _____ lbs.; **Blood Pressure:** _____ / _____ ( Sit / Stand)

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# History of Present Illness / Injury

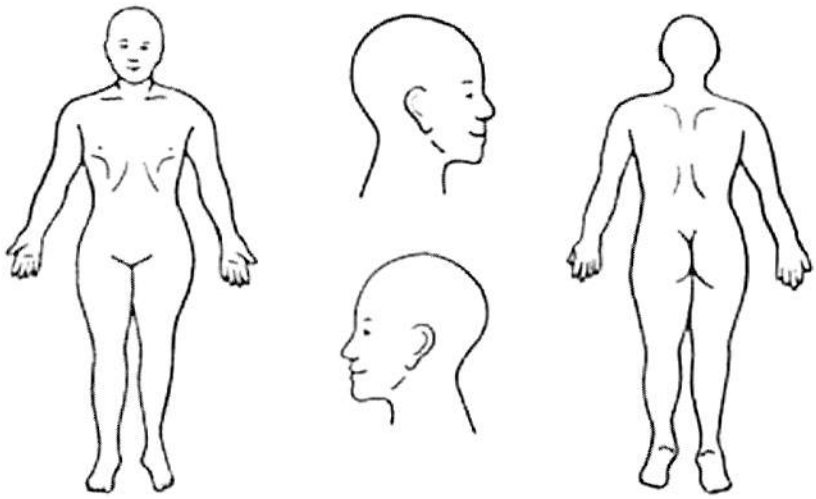
Fill out this section by marking the area with the described sensation using the appropriate symbols from the left.

X X X Burning Pain
( ( ( ( Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain

**Please Complete:**

____ Constant
____ Come & Go
____ Getting Better
____ Getting Worse
____ Staying Same

| Better: | | Worse: |
|---|---|---|
| ____ | AM | ____ |
| ____ | Mid-Day | ____ |
| ____ | PM | ____ |



## If Applicable, Rate Your Discomfort / Symptom(s):

Enter the number below that corresponds with your degree of discomfort. "0" is NO pain/symptom(s), "100" is intolerable Pain/Symptoms.

None — Discomfort Scale — Extreme!

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

## Why Have You Decided to Have Your Son / Daughter Evaluated by a Chiropractor?

- ☐ He/She is Continuing Ongoing Care from Another Chiropractor.
- ☐ I Recently Had My Spine Checked By a Chiropractor and Understand the Value in Getting My Child Checked.
- ☐ I Have Concerns About His/Her Health and I've Learned that Chiropractic May Be Able to Help.
- ☐ He/She is Extremely Active and I Want to be Sure Their Body Handles the Physical & Mental Strain
- ☐ I Want to Improve My Child's Immune Function & Overall Well-Being.

## Do You Have a Specific Concern for Your Child That Brings You In?

- ☐ No, I'm interested in having my child's spine and nervous system assessed to achieve optimal health and functioning.
- ☐ Yes. Please answer the following questions:

Describe Specific Symptom(s) or Concern(s): _____

How Did It Begin? _____ When Did It Start? _____

What Have You Tried So Far to Remedy the Problem(s): _____

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | Any Recent Loss of Appetite or Change in Eating Habits? | How? _____ |
| ☐ | ☐ | Any Recent Change in Bathroom Habits? | How? _____ |
| ☐ | ☐ | Any Change in Sleeping Habits? | How Many Times Does It Wake Them Up? _____ |
| ☐ | ☐ | Do They Sleep with a Pillow? How Many? _____ | Where are They Placed? _____ |
| | | ♦ What Positions Do They Sleep In? _____ | How Old is Their Mattress? _____ |

## What Makes the Condition Better?

Head / Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

## What Makes the Condition Worse?

Head / Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

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# Past Medical History

How Many Times Has Your Child Had the Condition That They Are Seeing Us for Today? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Has Your Child Suffered From Any of the Following Conditions Now or In the Past?

☐ ADD/ADHD ☐ Asthma ☐ Autism ☐ Back Pain ☐ Bed-Wetting ☐ Rashes ☐ Ear Infections
☐ Frequent Colds ☐ Scoliosis ☐ Growing Pains ☐ Headaches ☐ Tonsil Problems ☐ Head Tilt ☐ Stomach Pains
☐ Frequent Falls ☐ Anxiety ☐ Refusal to Eat ☐ Allergies ☐ Sports Injuries ☐ Learning Difficulties

YES NO

☐ ☐ **Does Your Child Suffer From Any Other Health Condition(s)?** (Diabetes, Cancer, Others) If YES, Please Explain:

_____

_____

☐ ☐ **Has Your Child Ever Seen a Chiropractor Before?**

- When Was the Last Time They Were Seen? _____ Which Dr.? _____
- For What Problem(s)? _____ Were They Helped? _____
- How Often Were They Being Seen? _____ Why Did You Leave? _____
- List Any Other Chiropractors Your Child has Seen in the Past: (Use More Paper as needed.)

| Date | Dr. Name | Condition(s) | Why Did You Leave? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ ☐ **Has Your Child Ever Seen a Medical Doctor for This Condition?** (Use More Paper as needed.)

| Date | Dr. Name | Condition(s) | Results |
|---|---|---|---|
| | | | ☐ Complete Recovery ☐ Complications |
| | | | ☐ Complete Recovery ☐ Complications |
| | | | ☐ Complete Recovery ☐ Complications |
| | | | ☐ Complete Recovery ☐ Complications |

☐ ☐ **Describe Any Major Illnesses, Injuries, Falls, Hospitalizations, Auto Accidents, and/or Surgeries:**

| Date | Dr. Name | Condition(s) | Results |
|---|---|---|---|
| | | | ☐ Complete Recovery ☐ Complications |
| | | | ☐ Complete Recovery ☐ Complications |
| | | | ☐ Complete Recovery ☐ Complications |
| | | | ☐ Complete Recovery ☐ Complications |

☐ ☐ Have They ever Had X-Rays? When? _____ What Body Parts? _____

☐ ☐ Does Your Child Try to "Crack" Their Own Neck and/or Back? Explain: _____

# Birth & Rearing History

Were There Any Complications During Pregnancy? ☐ No ☐ Yes, Explain: _____

Was Your Child's Birth: ☐ On Time ☐ Early ☐ Late Explain: _____

Was the Child's Delivery: ☐ Vaginal ☐ Cesarean (C-Section) How Long was Labor? _____

Was the Child Born: ☐ At Home ☐ In Hospital ☐ Who Was Your Midwife / Doctor? _____

What Was The Child's Birth Measurements? ☐ Weight: _____ ☐ Length: _____

YES NO

☐ ☐ Were Extraction Aids (Forceps/Suction) Used? _____

☐ ☐ Was There More Than One Fetus? If Yes, Explain: _____

☐ ☐ Did the Mother Use any Alcohol or Smoke During Pregnancy? If So, How Much? _____

☐ ☐ Did the Mother Use any Pre-Natal Vitamins? If No, Why Not? _____

☐ ☐ Is/Was Your Child Vaccinated? If Yes, Describe Any Adverse Reactions: _____

☐ ☐ Is/Was Your Child Breastfed? If Yes, Describe Any Difficulties: _____

☐ ☐ Did/Does Your Child Use Formula? If Yes, Describe Any Difficulties/Allergies: _____

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## Parental Instincts

**Do You Feel Your Child is Developmentally Appropriate for Their Age,**

**Intellectually:** ☐ **Yes** ☐ **No**, Explain: _____

**Emotionally:** ☐ **Yes** ☐ **No**, Explain: _____

**Physically:** ☐ **Yes** ☐ **No**, Explain: _____

What Is Your Primary Goal(s) for Your Child at Our Clinic? _____

_____

## Family Health History

**Health Status of Family Members.** (List Any Current or Past Health Conditions. Or if Deceased, at What Age and From What?)

Mother: _____

Father: _____

Sister(s): _____ How Many? _____

Brother(s): _____ How Many? _____

## System Review Questions

**Have You Had Any Problems with the Following Areas Now or in the Past?** (Please Mark **Y** for Yes or **N** for No in Each of the Following:)

1. ____ **Eyes** (glasses, Lazy Eye, pink eye, glaucoma, Etc.)
2. ____ **Ears, Mouth, Nose, Throat** (ear infections, sinus, Etc.)
3. ____ **Cardiovascular** (heart, murmur, irregular beat, Etc.)
4. ____ **Respiratory** (lungs, breathing, asthma, RSV, Etc.)
5. ____ **Neurological** (nerve issues, weakness, numbness, Etc.)
6. ____ **Endocrine** (Menstrual, hormonal imbalances, liver, Etc.)
7. ____ **Gastro-Intestinal** (acid reflux, constipation, diarrhea, etc.)
8. ____ **Genito-Urinary** (bed wetting, kidneys, bladder, hernias, Etc.)
9. ____ **Musculoskeletal** (breaks, arthritis, scoliosis, Etc.)
10. ____ **Skin** (rashes, dryness, psoriasis, eczema, hair, Chicken Pox, Etc.)
11. ____ **Dietary Sensitivity** (Dairy, Gluten, Corn, Flour, Sugar, Etc.)
12. ____ **Others:** _____

Please Describe in More Detail: _____

## Patient-Choice Treatment Options

**Check <u>ALL</u> the Boxes Below That Corresponds How You Would Like the Doctors to Approach Your Issue(s):**

- ☐ I simply wish to have just a few adjustments for symptom control, <u>then call as needed</u>.
- ☐ I would like the doctors to put me on a <u>Treatment Plan</u> to help me fully recover.
- ☐ I am interested in being shown any necessary <u>Stretches +/- Exercises</u> to help me heal faster.
- ☐ I would be open to <u>Vitamin/Supplement or other Product</u> recommendations to help my body through the healing phases.
- ☐ Once I complete my initial treatment plan, I'm interested in a <u>Maintenance Adjustment Schedule</u> to support my gains.

Notes:

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

D.C. / C.T. Signature: _____ Date: _____