

osborne family chiropractic

PEDIATRIC HISTORY FORM

Child's Name: _____ Home# (____)____ - _____

Mother's Name: _____ Work # (____)____ - _____

Father's Name: _____ Work # (____)____ - _____

Address: _____ City: _____ State: _____ Zip Code: _____

Birth Date: ____/____/____ Age: ____ Sex: **M** / **F** SS#: _____ - _____ - _____

Names and Ages of Siblings: _____

Previous Chiropractic Care? **Y** / **N** If yes, when and for what reason? _____

Who may we thank for referring you to our office? _____

HEALTH OBJECTIVES

Chief health concern? (describe in detail) _____

Other health concerns? _____

Reason for consulting us? _____

PRENATAL HISTORY

As many childhood and adult health problems arise from pregnancy or through events occurring during labor and delivery, the following information is vital in determining the onset of illness or injury.

Problems during pregnancy? _____

Circle type of birth: Vaginal / Forceps / Vacuum / Breech / Cesarean—planned or emergency?

Problems during labor/delivery? _____

Was there medication or anesthesia used during labor or delivery? **Y** / **N** If yes, please list: _____

Did the provider assist delivery with their hands? **Y** / **N** / **Unsure** If Yes, did he/she turn or pull the baby's head? **Y** / **N**

Was there any visible injury to the baby after delivery? **Y** / **N** / **Unsure**

If yes, please describe: _____

FEEDING HISTORY

Was your child breast fed? **Y** / **N** How long? _____ Was your child formula fed? **Y** / **N** How long? _____

If formula fed, list type(s) of formula used and reason for each: _____

Introduced to solids at: _____ months. Cows milk at: _____ months.

Does your child have food or juice allergies or intolerances? **Y** / **N**

If yes, please list: _____

Please briefly describe your child's current diet: _____

How could their diet be changed for the better? _____

DEVELOPMENT HISTORY

Are you concerned about any developmental delays? **Y** / **N** If yes, please list: _____

HEALTH HISTORY

According to the International Safety Council, 50% of children have fallen onto their heads during their first year in life.

Another study reveals that 1/4 million children are injured on playgrounds annually.

Has your child experienced any such jolts, falls, or traumas? **Y / N** If yes, please describe: _____

Please list all past and present athletic activities your child has participated in: _____

Does your child spend prolonged time sitting? **Y / N** Approximate hours a day: _____

Has your child ever been involved in an automobile accident? **Y / N** _____

Has your child ever been seen on an emergency basis? **Y / N** _____

List any other traumas, surgeries and/or hospitalizations: _____

Please check any of the following conditions your child has suffered from past and present:

Allergies Asthma ADHD/ADD Back Pain Bed Wetting Breathing Problems

Chicken Pox Colds Colic Diarrhea Digestive Problems Ear Infections

Fatigue Learning Disorders Growing Pains Headaches Irritability Measels

Meningitis Fevers Mumps Neck Pain Poor Posture Rashes Rubella

Seizures Scoliosis Sleeping Disorders Whooping Cough Other: _____

Please list all past and present drug treatments your child has received (Prescription & over-the-counter) and reasons for each: _____

_____ Were you informed of adverse reactions? _____

Has your child been screened by a doctor skilled in the detection of a scoliosis? **Y / N / Unsure**

Was your child vaccinated? **Y / N**

Did your child experience any immediate or delayed adverse reactions? **Y / N / Unsure**

If yes, please describe: _____

On a scale of **0 - 10** describe your child's stress level: (**0 = None / 10 = Extreme**) _____

On a scale of **0 - 10** describe your child's: (**0 = Poor / 10 = Excellent**) _____

Exercise: _____ Sleep: _____ Diet: _____ Emotional Health: _____ Overall Health: _____

Today, we are becoming more aware of how current technological lifestyles and practices expose our children's Nervous Systems to continual stresses. These result in Vertebral Subluxation. Current scientific research is showing the direct relationship between the function of the Nervous System and the function of the immune system. The integrity of the Nervous System is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by Dr. Ryan, who is qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

(Parent/Guardian Printed Name)

(Date)

(Parent/Guardian Signature)

