PEDIATRIC HEALTH HISTORY (0-24 month)

Baby's Name_____ DOB:_____ Age:_____ ☐ Male ☐ Female

Address _____City_____State_____Zip_____

Height _____ Weight _____ # of Siblings _____ Ages _____

Mother_____Cell#_____Father_____Cell#_____

Home Phone _____Mothers / Fathers Email_____

Pediatrician/Family MD _____ Office Location: _____

Who is responsible for this account? ☐ Mother SS#_____-_____-_____ ☐ Father SS#_____-_____-_____

Whom may we thank for referring you?_____ ☐ Phone Book ☐ Website ☐ Sign ☐ Other_____

Welcome to our office. We are honored that you have chosen our office to serve your family. Please know that we will care for your baby with the greatest respect and treat them as if they are our own.

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve for this child. *(Circle as many goals as you wish)*

Better Sleep	Freedom from Pain	Easier Breathing
Improved Nutrition & Diet	Improved Coordination	Eliminate Medications
Improved Overall Health	Stronger Immune System	

Other_____

Please take a moment to tell us about your pregnancy and birth experience: *(circle, highlight or write)*

1) Was this your first pregnancy? Yes No How many other births have you had?_____
2) How would you describe this pregnancy overall? Good Great Stressful (explain)_____
3) Did you take any medications? Yes No Why?_____
4) Any ultrasounds during this pregnancy? Yes No # & Why?_____
5) Problems during pregnancy? Yes No What? (breech, diabetes)_____
6) Place of birth: Home Birthing Center Hospital Other_____
7) Birth Provider: Lay Midwife Nurse Midwife OB-GYN Other_____
8) Was labor induced? Yes No Why?_____ Was anesthesia used? Yes No
9) How long was labor and delivery? _____hours what week did you give birth?_____ Wks.
10) Type of Birth: Vaginal Vacuum Forceps C-Section (Planned) C-Section (Emergency)
11) Any Birth Trauma? (bruising/dislocations/Dr. pulling to get out)_____
12) Was there any: Jaundice (Yellow) Cyanosis (Blue) Congenital Anomalies/Defects
    If yes, please explain_____
    Birth Weight_____ Birth Length_____ APGAR score?_____(out of 10) Unknown
13) Was your baby taken away immediately after birth? Yes No Why?_____
14) Was any medication given to your baby after birth? Yes No Why?_____

Continued on back...

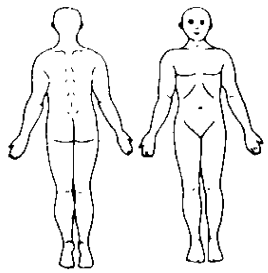
General History: *(circle, highlight or write where applicable)*

1) Did you breast feed your baby? Yes No how long?_____ Still Breastfeeding? Yes No
   Does your baby prefer one breast over the other? Yes No Preferred Breast? Left / Right
2) Did you feed your baby formula? Yes No Any problems?_____
3) Does your baby frequently spit up? Yes No how often?_____
4) Is your baby eating solid foods? Yes No what kinds?_____
5) Does your baby follow a special diet? Yes No _____
6) Does your baby sleep well? Yes No how often do they wake up during the night?_____
7) Does your baby have a preferred head position? (leans or turns one way) Yes No_____
8) Does your baby frequently arch their head and neck backwards? Yes No
9) At what age did your baby: Hold head up_____ Laugh_____ Roll over (front to back)_____
   Sit alone_____ Crawl_____ Stand_____ Walk (unassisted) _____
10) Any developmental challenges? Yes No Explain:_____
11) Does your baby have at least 1 bowel movement per day? Yes No If no, how often_____
12) Did you choose to vaccinate your baby? Yes No If yes, are they on a Traditional or Modified Schedule?
    Any adverse reactions from any vaccinations? Yes No_____
13) Any use of drugs or antibiotics? Yes No What & Why?_____

Current Complaint: *(circle, highlight or write where applicable)*

Baby's Primary Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)
b. Condition came on: Sudden Gradual How:_____ ***Mark areas below***
c. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk.)*** / Occasional ***(1/wk. or less)***
d. Feels worse in: AM Noon PM In Bed
e. What makes it better?_____
f. What makes it worse?_____
g. Has your child seen anyone for this? Yes No Who?_____
h. What were the results of the treatment?_____
i. Any medications taken for this problem?_____
j. How does this affect their life? *(circle/write)* poor school performance / irritability / interrupted sleep / fatigued restricted daily activities / hinders social activities / other_____



Other Complaints *(briefly describe)*_____

_____

_____

Health History: *(circle, highlight or write where applicable any **past or present** health challenges)*

Asthma	Sinus Problems	Allergies_____	
Frequent Colds	Ear Infections / Tubes	Seizures	Heart Condition
Colic	Constipation	Diarrhea	Digestive Disorder
Reflux	Stomach Aches	Poor Appetite	Sleeping Trouble

Falls over 3 ft. (high chair, changing station, counter, playground)_____

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Overall Health History: *(circle, highlight or write where applicable)*

1) List any allergies: No known / _____
2) Vitamins/Herbs/Minerals/etc.: None / _____
3) Current medications: None / _____
4) How many hrs. /day does your child spend in front of a TV, computer or video game?_____
5) Please rate the following for your child: (P) Poor, (G) Good or (E) Excellent

Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Spinal Health: *(circle, highlight or write where applicable)*

1) Has your baby ever had their spine and nervous system checked by a doctor of chiropractic before? Yes No
   Who?_____Date of last visit?_____Reason for ending care?_____
2) Have they ever had spinal x-rays taken? Yes No When?_____

Injuries/Surgeries: *(Date & Description)*

Auto Accidents: N/A / _____

Recreational Accidents: N/A / _____

Fractures / Dislocations: N/A / _____

Surgeries: N/A / _____

Family History:

Does anyone in your family suffer with any of the following conditions? *(Please circle or highlight Father &/or Mother)*

(F / M) Heart Disease (F / M) Strokes (F / M) Cancer (types):_____

(F / M) High BP (F / M) Thyroid (F / M) Neurological - Parkinson's, ALS, MS, other_____

(F / M) Diabetes (F / M) Asthma (F / M) Other_____

Other facts concerning the health of any other family members which may or may not be relevant to your baby's current state of health, but that you feel you would like the doctor to be aware of?_____

Consent to evaluate and treat a minor:

I, _____ being the parent or legal guardian of _____ have filled out the above information to be accurate to the best of my knowledge. After careful consideration I do hereby request and authorize a complete evaluation including 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.

I understand that I am directly and fully responsible to Wells Family Chiropractic, PLLC for all fees associated with chiropractic care my child receives whether or not paid by insurance.

The above information is true and accurate to the best of my knowledge.

_____	_____	_____	_____
Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date	Dr. Initials