PICO
FAMILY
CHIROPRACTIC CENTER

Pediatric Health History form:

Today's Date_____

Child's First Name:_____ Middle:_____ Last: _____

Child's Birth Date: _____ Male/Female

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

Mother's Name: _____ Father's Name: _____

Parent's Phone #: _____

Parents Email: _____

Reason for consulting our office?: _____

Health Profile:

Whom may we thank for referring you?: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

May we contact them (circle one): YES NO

Would you like appointment reminders? YES- EMAIL /TEXT NO

Why is this form so important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals at first are:

1. Address the issues that brought you to this office,
2. Offer you and your child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you into this office:

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐

If you came in today for a specific complaint, please fill out the next portion briefly describing it:

If he/she is experiencing pain, is it (check all that apply):

☐ Sharp ☐ Shooting

☐

☐ Burning Aching

☐ Dull ☐S Burning

☐ Comes and Goes ☐ Constant

☐ Travels ☐ Worse with movement

Since the problem started is it:

☐ Same ☐ Better ☐ Getting Worse

What makes it worse? _____

What does it interfere with? _____

Who else have you seen for the issue? _____

- Has it helped? _____

List medications the child is currently taking:

_____

_____

_____

Past surgeries, traumas or accidents:

_____

_____

Number of doses of antibiotics the child has taken:

_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Was IVF needed? Explain: _____

Third trimester presentation: ☐ Head down ☐ Breech ☐ Transverse ☐ Face/Brow

Were there any complications to the pregnancy? _____

Was Mom on any medications (prescription or over the counter)? _____

- If yes, please explain: _____

Did Mom or Dad ever smoke during pregnancy? Yes/No Who? _____

How many ultrasounds were performed? _____

Birth and Delivery:

Where was the baby born? ☐ Home ☐ Hospital ☐ Birthing center

☐ Other: _____ ☐ Transfer?

Was the delivery: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum/ Suction Cap

How long was labor? _____ How long was the delivery? _____

Was oxytocin/Pitocin used? Yes/No

Was an epidural used? Yes/No Apgar Scores: _____

Birth Weight _____ Length: _____

Congenital anomalies/Defects?_____

Were regular Well Baby Checks performed? _____ Where? _____

May we Contact them? _____

Check any box that applies **currently** *or* in the **past**:

- ☐ Seizures
- ☐ Ear/Sinus infection
- ☐ Asthma
- ☐ Allergies & congestion
- ☐ Failure to thrive
- ☐ Colic/Excessive crying
- ☐ Immune deficiency
- ☐ Headaches/migraines
- ☐ Vision/hearing issues
- ☐ Low energy & Fatigue
- ☐ Sensory/Spectrum
- ☐ ADD/ADHD
- ☐ Focus/Memory issues
- ☐ Anxiety/ Stress
- ☐ Speech issues
- ☐ Depression
- ☐ Reflux/GERD
- ☐ Chronic cough/colds
- ☐ Diabetes Mellitus type ____
- ☐ Bronchitis/Pneumonia
- ☐ Jaundice
- ☐ Eczema
- ☐ Food allergies
- ☐ Bedwetting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Lower Back pain
- ☐ Kidney issues
- ☐ Knock Knee
- ☐ Scoliosis

Age	Milestone	Met	Not Met	Delayed
1 Month	Fists clench			

2 Months	Smiles			
	Coos			
	Hands open			
3 Months	Head Control			
	Opens Mouth			
4 Months	Laughs			
	Push Up			
5 Months	Back→stomach			
6 Month	Sits alone in tripod			
	Reaches			
	1 Syll word "da"			
8 Months	Sits alone			
	Pincher grip			
	2 syll word "dada"			
10 Months	Pulls up to stand			
	Points			
11 months	Cruising			
12 Months	Stands alone			
	Walks w/support			
	Holds cup			
	Knows 2 words			
15 months	Walks alone			
	Crawls upstairs			
	Names objects			
	Marks with pencil			
	Says 4-5 words			
	Indicates wants			
18 Months	Runs			
	Points to body parts			
	Partially feeds self			

Infancy (Under 1 years old):

Was the infant vaccinated? Yes/No If Yes, List them with dates:

_____

_____

_____

Infant feeding: ☐ Breast ☐ Formula, Other:_____

Number of hours sleeping per night? _____

Quality of sleep? ☐ good ☐ fair ☐ poor

Was there any prolonged use of medications or an inhaler? Yes/No

- If yes, Explain: _____

Did the infant suffer any traumas such as serious falls or car accidents?

Yes/No If yes, Explain: _____

Has the infant ever been under regular chiropractic care? Yes/No

Childhood years(1years+):

Did the child have any childhood illnesses? Yes/No

- If yes, Explain: _____

Does the child play any youth sports? Yes/No

- If yes, which one(s)? _____

Has the child suffered from emotional traumas? Yes/No

Please give us any other health information you feel would be helpful:

_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to Pico Family Chiropractic Center to examine and care for my child.

Guardian's Signature: _____

Relationship to child: _____ Date signed: _____