PEDIATRIC HEALTH PROFILE

Today's Date______________________

Name (child): ____

Name (parents/ guardian): ____

Date of Birth (child): ____________Age: _________

Address: ____

City: _______________________ Postal Code: __________________

Home #: ______________________ Cell/Business #__________________

Date of Birth (parent): ___________Age: _____

Email address: _____________________________

Names/ ages of siblings: ____

If you (the parent/ guardian) are not currently a patient, whom may we thank for referring you and your child to our office? ______________________________________

Are you: ☐ here for a specific concern ☐ seeking wellness care

Expectations: ____

What is the child's major concern: ____

Have any other practitioners been consulted or other care been administered for this concern (please list):

____

Date of onset: ______________ Onset was: ☐ Sudden ☐ Gradual ☐ Associated with an event

Duration of problem (episode): ☐ minutes ☐ hours ☐ days ☐ months ☐ years

Aggravating factors: ____

Relieving factors: ____

BIRTH HISTORY

Assisted birth: ☐ No ☐ Yes, If yes: ☐forceps ☐ vacuum extraction ☐ C-section ☐ induced labor

Medications delivered to mother at birth? ☐ No ☐ Yes , If yes, what? ___________________

Duration of birth: _____ Birth weight: ___________

Complications at birth: ☐ No ☐ Yes If yes, explain: ___________________________________

Do your child's sleeping patterns seem normal to you: ☐ Yes ☐ No

GENERAL HEALTH HISTORY

Please check the appropriate box for any of the following symptoms that you have experienced within the last year.

NEUROLOGICAL

- O allergy
- O chills
- O convulsions
- O dizziness
- O fainting
- O fevers
- O headaches
- O loss of sleep
- O nervousness
- O depression
- O neuralgia
- O numbness
- O sweats
- O loss of weight
- O tremors

MUSCLE & JOINT

- O arthritis
- O bursitis
- O foot trouble
- O hernia
- O low back pain
- O neck pain
- O neck stiffness
- O pain between shoulders

RESPIRATORY

- O chest pain
- O chronic cough
- O difficulty breathing
- O spitting blood
- O throat phlegm
- O wheezing

EYES, EARS, NOSE & THROAT

- O colds
- O crossed eyes
- O deafness
- O dental decay
- O asthma
- O ear aches
- O ear noises
- O vomit blood
- O sinus infections
- O enlarged glands
- O enlarged thyroid
- O sore throat
- O tonsillitis
- O eye pain
- O failing vision
- O far sighted
- O gum trouble
- O hay fever
- O hoarseness
- O nasal obstruction
- O near sighted
- O nosebleeds

CARDIOVASCULAR

- O rapid heart beats
- O slow heart beats
- O swelling of ankle
- O hardening of arteries
- O high blood pressure
- O low blood pressure
- O pain over heart
- O poor circulation

GASTROINTESTINAL

- O excessive hunger
- O burping or gas
- O liver trouble
- O colitis
- O colon trouble
- O constipation
- O diarrhea
- O difficult digestion
- O distension of abdomen
- O stomach pain
- O gall bladder trouble
- O hemorrhoids
- O intestinal worms
- O jaundice
- O poor appetite
- O nausea
- O vomiting

SKIN

- O boils
- O bruise easily
- O dryness
- O hives or allergy
- O itching
- O skin rash
- O varicose veins

GENITOURINARY

O bed wetting
O blood in urine
O frequent urination
O loss control of urine
O kidney infection
O painful urination
O prostate trouble
O pus in urine
O smell of urine

PAIN OR NUMBNESS IN:

O shoulders
O arms
O hands
O hips
O legs
O knees
O ankles
O feet
O tail bone
O sciatica
O swollen joints

Since problems that Chiropractors concern themselves with can be related to many types of stressors, the following is also very important for us to know:

CHEMICAL STRESSORS

Was (is) this child breast-fed as an infant? ☐ No ☐ Yes – If yes, for how long? _____________
Food / Juice intolerance: ☐ No ☐ Yes Type: ____
Does the child take any supplements/ vitamins: _______________________________________
Does the child consume sugar on a regular basis? ☐ Yes ☐ No
Any pets at home: ______________ Any smokers in the home? ☐ No ☐ Yes
Any vaccinations? ☐ No ☐ Yes Any antibiotics? ☐ No ☐ Yes – list:_____________________
Has your child ever reacted to any medications? _______________________________________
Total # courses of antibiotics to date ________

PSYCHOSOCIAL STRESSORS

Any problems with bonding? ☐ No ☐ Yes
If the child has siblings, do they get along? ☐ No ☐ Yes
Does the child enjoy and/ or excel in school (if applicable)? ☐ No ☐ Yes
Any behavioral problems? ☐ No ☐ Yes – Onset: ____
Any night terrors, sleep walking, difficulty sleeping? ☐ No ☐ Yes - Specify: ___________________

PHYSICAL STRESSORS

Any trauma during pregnancy (falls, accidents)? _______________________________________
Any evidence of birth trauma? - bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other?: __________________
____
Any falls (including from couches, beds, change tables) or accidents : ☐ No ☐ Yes
if yes, please specify: ____
Did the child crawl before they walked? ☐ No ☐ Yes
Any trauma with bruising, cuts, stitches, fractures? ☐ No ☐ Yes
What activities does the child participate in? ____

Please identify the practitioners on your child’s healthcare team:

Family Physician	Dentist
Name: ___________________________________	Name: _______________________________
Location: _________________________________	Location: _____________________________
Naturopathic Doctor/ Homeopath	**Other**
Name: ____________________________________	Name: _______________________________
Location: __________________________________	Location: _____________________________

Is there anything else you feel we should know?

____

____

Signature of parent/ guardian: _______________________________ Date: ___________________