PRE-SCHOOL CHILD HISTORY

(3 to 5 years of age)

Date: _____ Name of Mother: _____ Name of Father: _____

Name of child: _____ Sex: M F Date of Birth: ___/___/____ Age: ____

The reason for today's visit: _____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur? _____
Was the onset sudden or gradual? _____
Is the problem constant or intermittent? _____

☐ ☐ Has your child ever had this problem before? _____

☐ ☐ Has your child previously been treated for this problem? By whom? _____

☐ ☐ Has your child previously had chiropractic care?
If yes, where? _____ If yes, by whom? _____

NUTRITION:

☐ ☐ Do you have any concerns about your child's diet? _____

☐ ☐ Does your child have any food allergies? _____

☐ ☐ Does your child have any persistent or intermittent occurring skin rashes? _____

☐ ☐ Does your child take vitamin supplements? _____

☐ ☐ Does your child eliminate stools each day? _____

For how many months was your child breast-fed? _____

What does your child usually eat for Breakfast? _____

Lunch? _____ Dinner? _____

Snacks? _____ Favorite Food? _____

How much does your child drink each day of: Water _____ Cow's Milk _____

Soda/Pop _____ Juice/Sports Drinks _____

What type of fast foods does your child like to eat? _____

TRAUMA:

☐ ☐ Has your child had any recent falls or trauma? _____
Describe the trauma and the date it occurred _____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?
_____

☐ ☐ Has your child ever fallen downstairs or from a significant height? _____

☐ ☐ Has your child ever been in a motor vehicle collision or a near miss? _____

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

☐ ☐ Has your child had any other trauma or injuries? _____

☐ ☐ Does your child bang his/her head repeatedly against a wall, bed or other object? _____

☐ ☐ Does your child enjoy participating in any organized sports? _____

HEALTH HISTORY:

☐ ☐ Does your child ever complain of back or neck pain? _____

☐ ☐ Does your child ever complain of pains in the legs or arms? _____

☐ ☐ Does your child ever complain of headaches? _____

☐ ☐ Has your child had asthma? _____

☐ ☐ Is your child allergic to anything? _____

☐ ☐ Are there any smokers in the child's home? _____

☐ ☐ Has your child had any earaches?
At what age did the child's first earache occur? _____
How frequently does your child have earaches? _____
Do the earaches tend to occur in the same ear? Right ☐ Left ☐ Both ☐

☐ ☐ Is your child presently taking any prescribed medication? _____

Please list any other illnesses that have been a concern for your child _____
_____

Please list any surgeries your child has had _____
_____

Do you have any other concerns about your child's health? _____

History of Birth

Date: ___ /___ /___ Name of Child: _____ Date of Birth: ___ /___ /___

LABOR AND DELIVERY:

What was your first sign of labor? _____

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours/minutes

	Yes	No	
Hospital birth	☐	☐	
Name of Hospital:			_____
Physician/Midwife:			_____
Home birth	☐	☐	
Midwife:			_____
Birth Center birth	☐	☐	
Name of Birth Center:			_____
Physician/Midwife:			_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	If yes, why? _____
Emergency C-section	☐	☐	_____
Was Birth Induced	☐	☐	_____
Pitocin:	☐	☐	_____
Breaking bag of waters:	☐	☐	_____
Suppository:	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	

At what point during labor was anesthesia administered? _____

What type of anesthesia was used? _____

Fetal distress	☐	☐	_____
Meconium staining	☐	☐	_____
Episiotomy/Tearing	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

APGAR Scores: At 1 minute _____/10 At 5 minutes _____/10

Baby's Crying: Baby Cried Immediately After Birth ☐ Cried Strongly ☐ Weak Cry ☐
Baby Did Not Cry for _____minutes

Baby's Color: Pink all over ☐ Blue face ☐ Blue Hands/Feet ☐ Jaundice ☐

Baby's Head: Bruised ☐ Swollen ☐ Red ☐ Misshapen ☐

Baby's Activity: Arms and legs actively moving ☐ Floppy baby ☐

Signs of Trauma: Yes ☐ No ☐

Intensive Care: Was required ☐ Days in Neonatal Intensive Care Unit _____

Medication given at birth (to baby): _____
(to mom): _____

Vaccines administered: _____ Vitamin K ☐ Circumcision ☐

Tests run: _____

Birth weight: _____lbs._____oz. Birth length: _____in.

Baby home on day_____ Mom home on day _____

Breastfeeding: Latched on right away ☐ Difficulty feeding ☐ Didn't Breastfeed ☐

PATIENT INFORMATION

Date: _____

Patient Name: _____ Day Phone: _____

Address: _____ Night Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Date of Birth: ___/___/___ Age: _____ Patient's Social Security Number: ____ - ____ - ____

E-mail Address: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Referred to this office by: Friend/Relative Yellow Pages Insurance Company Other

INSURANCE INFORMATION

Who is responsible for this account? _____

Insurance Company: _____

Group Number: _____ ID Number: _____

Subscriber's Name: _____ Employer: _____

Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____

Relationship to patient: _____

Is patient covered by additional insurance? Yes No

Insurance Company: _____

Group Number _____ ID Number _____

Subscriber's Name: _____ Employer: _____

Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____

Relationship to Patient: _____

Name of Pediatrician: _____ Location of Pediatrician _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also hereby authorize Dr. _____ and whomever she may designate as assistants to administer chiropractic care as deemed necessary for _____ (name of child).

I give Dr. _____ permission to contact my child's pediatrician regarding his/her care? Yes No

_____ _____

Responsible Party Signature Relationship