Beverly Family chiropractic

# Children's Health History

Date _____ / _____ / _____
Month Day Year

Name: _____ ☐ Male ☐ Female

Birth Date (MM/DD/YYYY): _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Postal Code: _____

Mother's/Guardian's Name _____

Best Phone: (  ) _____ ☐ Cell ☐ Home ☐ Work Email: _____

Father's/Guardian's Name _____

Best Phone: (  ) _____ ☐ Cell ☐ Home ☐ Work Email: _____

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

Reason for contacting our office: _____

_____

_____

Other professional your child has seen for this concern: _____

Please list any treatments and results: _____

Other health concerns: _____

_____

_____

Family health history: _____

_____

Your child's Pediatrician: _____ Date of last visit (MM/DD/YYYY): _____

Reason: _____

Your child's previous Chiropractor: _____ Date of last visit (MM/DD/YYYY): _____

Reason: _____

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## Chemical Stressors

Rate the mother's diet during pregnancy (on a 1-10 scale with 10 being best): Worst ‹ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☑9 ☐10 › Best

Mother smoked during pregnancy? ☐ No ☐ Yes Any smokers at home? ☐ No ☐ Yes _____

Drugs taken during pregnancy? ☐ No ☐ Yes If yes, which ones? _____

Ultrasounds during pregnancy? ☐ No ☐ Yes If yes, how many? _____

Any invasive procedures (amniocentesis, CVS)? ☐ No ☐ Yes _____

Was this child breastfed? ☐ No ☐ Yes If yes, for how long? _____

Was formula introduced? ☐ No ☐ Yes If yes, at what age? _____

Was cow's milk introduced? ☐ No ☐ Yes If yes, at what age? _____

Any food intolerances? ☐ No ☐ Yes If yes, which foods? _____

Number of doses of antibiotics your child has taken? _____

Other prescription medication your child has taken? _____

Vaccine history: _____

Vaccine reactions (please check): ☐ High pitched screaming ☐ Nonstop crying ☐ Fever ☐ Rashes ☐ Hives
☐ Convulsions ☐ Seizures ☐ Other: _____

Any digestive problems? ☐ No ☐ Yes _____

Any skin problems? ☐ No ☐ Yes _____

## Physical Stressors

Any trauma during pregnancy? ☐ No ☐ Yes _____

Any evidence of birth trauma: ☐ Bruises ☐ Odd shaped head ☐ Stuck in birth canal ☐ Excessively long birth
☐ Respiratory problems ☐ Cord around neck ☐ Other: _____

Any falls from couches, beds, changing tables? ☐ No ☐ Yes _____

Any traumas with bruising, cuts, stitches, fractures? ☐ No ☐ Yes _____

Any hospitalizations, surgeries or organs removed? ☐ No ☐ Yes _____

Sports played and age began? _____

Weight of school backpack? _____

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## Emotional Stressors

Please rate the mother's stress during pregnancy (on a 1-10 scale with 10 being the most severe):

Mild ‹ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 › Severe

Was the child allowed to bond immediately after delivery? ☐ No ☐ Yes _____

Any behavioral problems? ☐ No ☐ Yes _____

Any ☐ Night terrors ☐ Sleep walking or ☐ Difficulty sleeping? _____

Average number of hours of television/computer/iPad/iPod/video games per week? _____

## Growth and Development

Any signs that your child is not developing properly? ☐ No ☐ Yes _____

Any growing pains? ☐ No ☐ Yes _____

How many times has your child been sick in the last year? _____

Do your child's sleeping patterns seem normal to you? _____

## Birth History

Please check all that apply:

☐ Hospital ☐ Home Birth ☐ Birthing Center ☐ Midwife ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Induced

Any complications during birth? ☐ No ☐ Yes _____

_____

Medications given to mother during labor? ☐ No ☐ Yes _____

Duration of birth: _____ hours APGAR at birth: _____ APGAR after 5 minutes: _____

Was the infant alert and responsive within 12 hours of delivery? ☐ No ☐ Yes If no, explain: _____

_____

*I authorize Beverly Family Chiropractic and their doctors to perform a comprehensive examination of my child's spine and nervous system.*

Parent/Guardian Name (print): _____

Signature: _____ Date (MM/DD/YYYY): _____