pediatric health record

ABOUT THE CHILD

NAME	
DATE OF BIRTH:	AGE:
GENDER:	YEAR IN SCHOOL?

ABOUT THE PARENTS

MOTHER'S NAME:	
MOTHER'S ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
FATHER'S NAME:	
FATHER'S ADDRESS: (If different from above)	
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	

CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU?	
HAS YOUR CHILD EVER BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ○ YES ○ NO	DOCTOR'S NAME:
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?	APPROXIMATE DATE OF LAST VISIT:
HAS ANYONE IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?	
ARE YOU INTERESTED IN ENHANCING THE HEALTH OF THE ENTIRE FAMILY?	

BIRTH HISTORY

WERE THERE ANY COMPLICATIONS TO THE PREGNANCY?

DESCRIBE THE DELIVERY:

- ○ LABOR CHEMICALLY INDUCED
- ○ C-SECTION DELIVERY
- ○ DOCTOR PULLED OR TWISTED BABY
- ○ EPIDURAL ADMINISTERED
- ○ LABOR WAS DOCTOR ASSISTED
- ○ FORCEPS/VACUUM EXTRACTION
- ○ PREMATURE DELIVERY
- ○ MIDWIFE or DOULA PRESENT

PLEASE EXPLAIN:

LENGTH OF DELIVERY	PRESENTATION AT BIRTH
WAS YOUR CHILD BREASTFED OR FORMULA RAISED?	

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

WHEN DID THIS BECOME A CONCERN?	HAS THIS CONDITION: ○ GOTTEN WORSE ○ STAYED THE SAME ○ GOTTEN BETTER
DOES THIS CONDITION INTERFERE WITH: ○ SCHOOL ○ SLEEP ○ DAILY ROUTINE ○ OTHER ACTIVITIES PLEASE EXPLAIN:	HAS THIS CONDITION OCCURRED BEFORE? ○ YES ○ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ○ YES ○ NO	DOCTOR'S NAME & SPECIALTY:

TYPE OF TREATMENT:

RESULTS:

Please write any other information about the child that you feel may be helpful for us to be aware of.

medical history

CHILD'S HEALTH HISTORY

DESCRIBE YOUR CHILD'S BOWEL HABITS.
(Frequency, Consistency, etc)?

WHEN DID YOUR CHILD START CRAWLING?

How long did they crawl before walking?

WHEN DID YOUR CHILD START WALKING?

HAVE YOU EVER NOTICED DELAYED LANGUAGE DEVELOPMENT? ○ YES ○ NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ○ YES ○ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ○ YES ○ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SEVERE FALL? ○ YES ○ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ○ YES ○ NO
PLEASE EXPLAIN:

IS YOUR CHILD ACCIDENT PRONE? ○ YES ○ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ○ YES ○ NO
PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ○ YES ○ NO
PLEASE EXPLAIN:

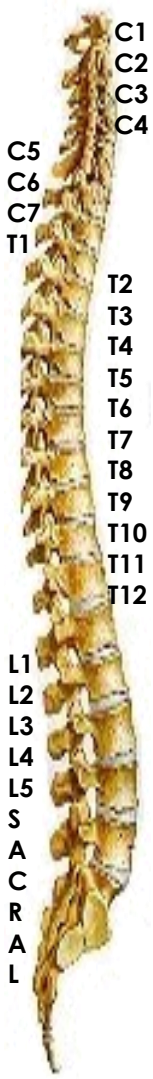
DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
○ YES ○ NO PLEASE EXPLAIN:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

CHILD'S SYMPTOMS

INSTRUCTIONS: *Please* ***circle*** *the health concerns or conditions your child has EVER experienced. Each area of concern relates to proper nerve function.*

Sore Throat
Thyroid Dysfunction
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Breathing Problems
High Blood Pressure
Heart Conditions
Cholesterol Issues



Headaches
Migraines
Seizures / Epilepsy
Dizziness / Vision Issues
Allergies / Sinus Problems
Sleep Issues
Immune Dysfunction
Ear Aches/Infections
Frequent Colds
Attention / Focus Issues
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Stones

Rash or Skin Problems
Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bedwetting
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

_____
_____
_____
_____
_____
_____
_____
_____
_____

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ○ YES ○ NO	**DID YOU OPT FOR A DELAYED SCHEDULE?** ○ YES ○ NO	**HAVE YOU OPTED FOR MERCURY-FREE VACCINES?** ○ YES ○ NO

CHECK IF YOUR CHILD HAS RECEIVED THE FOLLOWINGVACCINATION(S):

○ VITAMIN K ○ HEPATITIS B ○ HEPATITIS A ○ ROTAVIRUS ○ DTap ○ MMR ○ CHICKEN POX
○ PNEUMOCOCCAL ○ GARDASIL ○ INACTIVATED POLIO ○ MENINGITIS ○ H1N1 ○ FLU

○ OTHER _____

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

LIFESTYLE HEALTH HABITS

EXERCISE & SLEEP HABITS

INSTRUCTIONS: *Please check all that apply to your normal lifestyle routine.*	
❑ DO YOU EXERCISE? IF SO, HOW?	
WHAT IS YOUR FAVORITE SPORT OR ACTIVITY?	WHAT ROLE DOES EXCERISE & SPORTS PLAY IN YOUR LIFE?
WHAT DO YOU DO FOR FUN?	
WHAT TIME DO YOU WAKE UP?	WHEN IS YOUR BEDTIME?
DO YOU SLEEP WELL?	DO YOU HAVE NIGHTMARES?
IS IT HARD TO SEE OR READ?	DO YOU ENJOY READING?

GIRLS ONLY

ARE YOUR PERIODS REGULAR?	HOW MANY DAYS IS YOUR FLOW?
ARE YOUR PERIDOS PAINFUL OR SYMPTOMATIC? Explain ..,	
BIRTH CONTROL HISTORY	

FAMILY HISTORY

Do you experience any of the following? If so, please explain …	
WHAT IS THE HEALTH OF YOUR MOTHER?	
WHAT IS THE HEALTH OF YOUR FATHER?	
WHAT IS YOUR ANCESTRY?	WHAT IS YOUR BLOOD TYPE?

GENERAL HISTORY

Do you experience any of the following? If so, please explain …
HEADACHES OR EAR INFECTIONS?
CONSTIPATION / DIARRHEA / GAS / BELLY PAIN?
ALLERGIES OR SENSITIVITIES?
RECURRING INFECTIONS OR YEAST ISSUES?
DOES ANYTHING ELSE HURT?

DIETARY HABITS

What foods did you eat often as a child?				
BREAKFAST	**LUNCH**	**DINNER**	**SNACKS**	**FLUIDS**

Whats your food like these days?				
BREAKFAST	**LUNCH**	**DINNER**	**SNACKS**	**FLUIDS**

INSTRUCTIONS: *Please check each item that you eat, drink or use regularly:*

❑ ALCOHOL	❑ FAST FOOD REGULARLY	❑ MILK PRODUCTS	❑ DISTILLED WATER	❑ FRIED FOODS	❑ FRESH FRUITS
❑ CHEW TOBACCO	❑ CARBONATED BEVERAGES	❑ SOY PRODUCTS	❑ TAP WATER	❑ COFFEE	❑ FRESH VEGGIES
❑ CIGARETTES	❑ REFINED SUGARS	❑ CANDY	❑ HERBAL TEAS	❑ LUNCH MEATS	❑ MARGARINE
❑ GMO-FOODS	❑ REFINED (WHITE) FLOUR PRODUCTS	❑ ARTIFICIAL SWEETENERS	❑ NON-HERBAL TEAS	❑ ORGANIC MEAT	❑ BUTTER

❑ VITAMINS/SUPPLEMENTS/MEDICATIONS:

ABOUT YOUR FOOD SOURCES

WHAT PERCENTAGE OF YOUR FOOD IS HOME-COOKED?	DO YOU COOK?
WHERE DO YOU GET THE REST FROM?	
WHAT FOODS DO YOU WISH YOU COULD EAT MORE OFTEN?	
WHAT FOODS DO YOU WISH YOU NEVER HAD TO EAT AGAIN?	
WHAT DO YOU WANT TO LEARN ABOUT YOUR BODY AND/OR FOOD?	
ANYTHING ELSE YOU WANT TO SHARE ….	

What fun things do you do with your family?
What are your favorite things to do when you are alone?
Do you enjoy school?

general HEALTH HISTORY

NAME: _____ **DATE:** _____

DIRECTIONS:

Please read each description and circle the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a ? *before* the symptom's number.

KEY: 0 = Never 1 = Mild 2 = Moderate 3 = Severe

MINERALS				
1. Frequent skin rashes and/or hives	0	1	2	3
2. Muscle-leg-toe cramping at rest and/or while sleeping	0	1	2	3
3. Fever easily raised / fevers common	0	1	2	3
4. Crave chocolate	0	1	2	3
5. Feet have bad odor	0	1	2	3
6. Hoarseness frequent	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. Joint stiffness after rising	0	1	2	3
9. Vomit frequently	0	1	2	3
10. Tendency to anemia	0	1	2	3
11. "whites" of eyes (sclera) blue	0	1	2	3
12. "Lump" in throat	0	1	2	3
13. Dry mouth, eyes, and/or nose	0	1	2	3
14. White spots on finger nails	0	1	2	3
15. Cuts heal slowly and/or scar easily	0	1	2	3
16. Reduced or "lost" sense of taste and/or smell	0	1	2	3
17. Susceptible to colds, fevers, and/or infections	0	1	2	3
18. Strong light irritates eyes	0	1	2	3
19. Noises in head or ringing in ears	0	1	2	3
20. Burning sensations in mouth	0	1	2	3
21. Numbness in hands and feet (extremities "go to sleep")	0	1	2	3
22. Intolerant to MSG (monosodium glutamate)	NO		YES	
23. Cannot recall dreams	0	1	2	3
24. Nose bleeds frequent	0	1	2	3
25. Bruise easily, "black and blue" spots	0	1	2	3
26. Muscle cramps, worse with exercise ("charley horses")	0	1	2	3

MICROBIOME				
1. Coated tongue or "fuzzy" debris on tongue	0	1	2	3
2. Nasal congestion or discharge	0	1	2	3
3. Restless, figidity	0	1	2	3
4. Unproductive cough at night or while at rest	0	1	2	3
5. Urinary urgency or frequency	0	1	2	3
6. Burning on urination	0	1	2	3
7. Burning or itching anus	0	1	2	3
8. Bedwetting	0	1	2	3
9. Grind teeth at night	0	1	2	3
10. Recurrent ear infections or fluid in ears	0	1	2	3
11. Ear pain or deafness	0	1	2	3
12. Fingernail or toe nail fungus	0	1	2	3
13. Skin peeling on bottom of feet or hands	0	1	2	3

MAGNESIUM				
1. Blood pressure increased / on BP medication	0	1	2	3
2. Headaches	0	1	2	3
3. Hot flashes	0	1	2	3
4. Difficulty falling asleep	0	1	2	3
5. Tingling extremities or Restless Legs Syndrome	0	1	2	3
6. FEMALE ONLY: Hair growth on face or body	0	1	2	3
7. FEMALE ONLY: Masculine tendencies	0	1	2	3

CARDIOMETABOLIC				
1. Aware of heavy and/or irregular breathing	0	1	2	3
2. Discomfort in high altitudes	0	1	2	3
3. "Air hunger" / sigh frequently	0	1	2	3
4. Swollen ankles (worse at night)	0	1	2	3
5. Shortness of breath with exertion	0	1	2	3
6. Dull pain in chest and/or pain radiating into left arm	0	1	2	3
7. High blood pressure (with or without medication)	0	1	2	3
8. History of heart attack or cardiac event	0	1	2	3

B VITAMINS and FOLATE NEED				
1. Muscle soreness after moderate exercise	0	1	2	3
2. Vulnerability to insect bites—Especially fleas & mosquito	0	1	2	3
3. Loss of muscle tone or "heaviness" in arms or legs	0	1	2	3
4. Enlarged heart and/or heart failure	0	1	2	3
5. Worrier, feel insecure and/or highly emotional	0	1	2	3
6. Lack of concentration1	0	1	2	3
7. Pulse slow/below 65 or irregular pulse	NO		YES	
8. "Splitting" type headaches	0	1	2	3
9. Memory failing	0	1	2	3
10. Tolerance for sugar reduced	0	1	2	3

SECTION H—HEAVY METALS				
1.. Difficulty gaining weight, even if large appetite	0	1	2	3
2. Heart palpitations	0	1	2	3
3. Nervous, emotional, and/or can't work under pressure	0	1	2	3
4. Insomnia	0	1	2	3
5. Inward trembling	0	1	2	3
6. Night sweats	0	1	2	3
7. Fast pulse at rest	0	1	2	3
8. Intolerant to high temperatures	0	1	2	3
9. Easily flushed	0	1	2	3

TERMS OF ACCEPTANCE

When a patient seeks holistic care and we accept a patient for care, it is essential for both to be working towards the same objective. Our office has only one goal—to improve the function of the human body. I will alert the doctor and/or staff if I do not understand or accept part of treatment.

I hereby authorize the Doctor to work with my condition through the use of chiropractic adjustments, nutritional supplements, massages, exercises and/or other therapies, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I understand that the Webster technique is a specific chiropractic analysis and adjustment. The goal of the adjustment is to reduce the effects of sacral subluxation and or SI joint dysfunction. In so doing neuro-biomechanical function in the pelvis is improved.

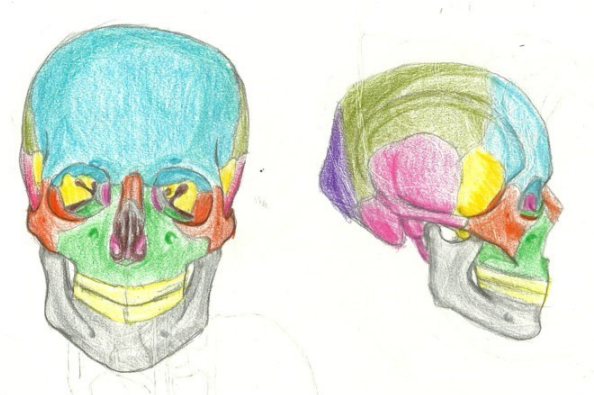
SIGNATURE OF PARENT OR GUARDIAN:	DATE:
PRINTED NAME OF PARENT OR GUARDIAN:	

** FOR OFFICE USE ONLY ** TO BE COMPLETED BY DOCTOR **

HEIGHT:	WEIGHT:	HAND DOMINANCE	FOOT DOMINANCE	EYE DOMINANCE

Primitive Reflex	Present	Primitive Reflex	Present
GALANTS		TONIC NECK	
MORO		BLINKING	
PEREZ		BABINSKI	
ROOTING		ACOUSTIC BLINK	
DIGITAL RESPONSE		FENCER RESPONSE	
PALMAR GRASP		ROTATION	
VERTICAL SUSPENSION		PLACING RESPONSE	

CRANIAL PATTERNS | IMBALANCES



** FOR OFFICE USE ONLY ** TO BE COMPLETED BY DOCTOR **

HEAD CARRIAGE:
❑ ANTERIOR ❑ POSTERIOR ❑ R FLEX ❑ L FLEX

CERVICAL CURVE:
❑ NORMAL ❑ HYPO ❑ HYPER

THORACIC CURVE:
❑ NORMAL ❑ HYPO ❑ HYPER

LUMBAR CURVE:
❑ NORMAL ❑ HYPO ❑ HYPER

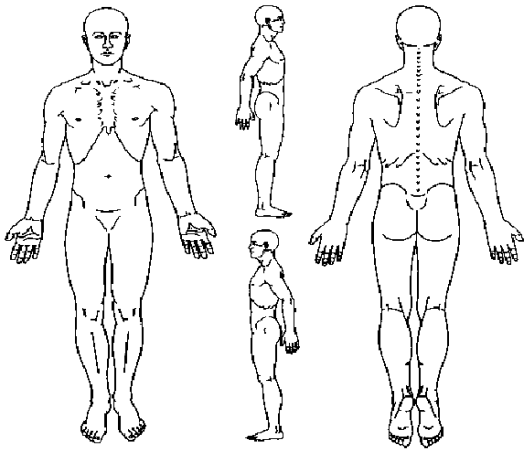
BILATERAL WEIGHTS:
_____ ❑ L ❑ R _____

SHORT LEG: DF + --
Supine ❑ L ❑ R **Prone** ❑ L ❑ R

FOOT FLAIR:
Supine ❑ L ❑ R Standing ❑ L ❑ R

BLOOD PRESSURE:
Supine _____/_____ Standing _____/_____

HEIGHT:	PULSE:	pH:
WEIGHT:	RESPIRATION:	TONGUE:



HIATAL HERNIA ICV VOH

TECHNOLOGICAL ASSESSMENT ORDERS

THERMAL			POSTURE PIC		
sEMG			CWAS		
PWP / HRV			IRIDOLOGY		
ROM			IODINE		
FOOT SCAN			ZINC		