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CHILD/ADOLESCHENT HISTORY

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

PATIENT'S FULL NAME ____________________ AGE ____ SEX ____ BIRTHDATE month/day/yr _____/_____/_____

NAME YOU PREFER TO BE CALLED ____________________ PARENT'S NAMES ____________________

ADDRESS ____________________ CITY ____________________ POSTAL CODE ______________

PHONE: HOME____________________ PARENT'S CELL____________________ WORK PHONE ____________________ (Mother, Father, Other)

PARENT'S EMAIL ADDRESS ____________________FAMILY PHYSICIAN ____________________

CHIROPRACTOR ____________________ SPECIALIST ____________________

WHO REFERRED YOU TO AND/OR HOW DID YOU LEARN OF THIS OFFICE? ____________________

PRESENT HEALTH PROBLEMS: PLEASE LIST MOST IMPORTANT HEALTH CONCERNS / PROBLEMS

____

____

____

MEDICATIONS:

	Now	Past	Frequency
ASPIRIN	___	___	_______
TYLENOL	___	___	_______
ANTIBIOTICS	___	___	_______
DECONGESTANTS	___	___	_______
_______________	___	___	_______

SUPPLEMENTS:

	Now	Past	Frequency
VITAMINS	___	___	_______
MINERALS	___	___	_______
FLUORIDE	___	___	_______
HERBS	___	___	_______
___________	___	___	_______

ALLERGIES: (to medications, pollens, animals or food)

CHILDHOOD ILLNESSES:

___ CHICKEN POX
___ MEASLES
___ MUMPS
___ RUBELLA
___ SCARLET FEVER
___ RHEUMATIC FEVER
___ STREP THROAT
___ PNEUMONIA
___ MONONUCLEOSIS
___ EAR INFECTIONS
___ TONSILLITIS
___ OTHER _______________

IMMUNIZATIONS: (age given, any adverse reactions?)

___ DPT (Diptheria, Pertussis, Tetanus)
___ MMR (Measles, Mumps, Rubella)
___ POLIO
___ HAEMOPHILUS INFLUENZA type B (Meningitis)
___ HEP-B (Hepatitis B)

PATIENT'S MEDICAL HISTORY:

	Now	Past	Never
ACNE	___	___	___
ALLERGIES	___	___	___
ANEMIA	___	___	___
ASTHMA	___	___	___
BED WETTING	___	___	___
BIRTH DEFECTS	___	___	___
COLIC	___	___	___
CONSTIPATION	___	___	___
COUGH/WHEEZE	___	___	___
CRADLE CAP	___	___	___
DEPRESSION	___	___	___
DIARRHEA	___	___	___
DIZZY SPELLS	___	___	___
EARACHES	___	___	___
ECZEMA	___	___	___
EXPOSURE TO:			
CIGARETTE SMOKE	___	___	___

	Now	Past	Never
EPILEPSY/SEIZURES	___	___	___
FATIGUE	___	___	___
FREQUENT INFECTIONS	___	___	___
HEADACHES	___	___	___
HEART MURMUR	___	___	___
HIGH FEVER	___	___	___
HYPERACTIVITY	___	___	___
INSOMNIA	___	___	___
JAUNDICE	___	___	___
LEARNING DISORDER	___	___	___
MOODINESS	___	___	___
STUFFY NOSE	___	___	___
THRUSH	___	___	___
VOMITING SPELLS	___	___	___
OTHER _____________	___	___	___

SURGERIES (YEAR & TYPE)

____

____

____

HOSPITALIZATIONS (YEAR & REASON) ____________________

____

____

INJURIES/ACCIDENTS (YEAR & CAUSE) ____________________

____

____

OTHER CONDITIONS ____________________

____

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* ______ MOTHER (age)* ______ BROTHERS (ages)* ________________ SISTERS (ages)* ________________

* If deceased, Please list age at death and circle.

IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1, B2, S1, etc.).

___ ALCOHOLISM	___ BLEEDING DISORDER	___ HEART DISEASE	___ OBESITY
___ ALLERGIES	___ CANCER of __________	___ HEARING LOSS	___ STOMACH ULCERS
___ ANEMIA	___ COLITIS	___ HIGH BLOOD PRESSURE	___ STROKE
___ ARTHRITIS	___ DIABETES	___ HYPOGLYCEMIA	___ THYROID DISORDER
___ ASTHMA	___ ECZEMA	___ KIDNEY DISEASE	___ TUBERCULOSIS
___ BIRTH DEFECTS	___ EPILEPSY	___ MENTAL ILLNESS	___ OTHER ________________________

DOES PATIENT HAVE ANY OF THE ABOVE? ______ IF YES, WHICH ONES ____

PRENATAL / BIRTH / FEEDING HISTORY:

1. MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS PATIENT

___ AGE	___ TRAUMA/INJURY	___ ALCOHOL CONSUMPTION	___ OTHER ________________________
___ BLEEDING	___ STRESS	___ DRUGS	___ TOXEMIA
___ NAUSEA	___ HIGH BLOOD PRESSURE	___ SMOKING	
___ ILLNESS	___ X-RAYS	___ MEDICATIONS ____	

2. TERM ___ PREMATURE ___ FULL BIRTH WEIGHT ____________________________

3. WAS PREGNANCY / BIRTH ___ GOOD? ___ DIFFICULT? ___ C-SECTION?

4. FEEDING OF INFANT
   BREAST FED __________ HOW LONG? ____________ COW'S MILK? ____
   FORMULA FED ________ HOW LONG? ____________ TYPE OF FORMULA ____
   AGE SOLID FOODS BEGUN ____________________________ WHAT FOODS? ____
   ANY FOOD ALLERGIES OR INTOLERANCES? _____________ TO WHAT FOODS? ____

5. SAMPLE DAILY DIET (Choose a typical day and include food and liquids)

SOCIAL HISTORY:

1. PARENTS: ___ MARRIED ___ SEPARATED ___ DIVORCED
   MOTHER'S OCCUPATION ______________________________ ___ FULL TIME ___ PART TIME
   FATHER'S OCCUPATION ______________________________ ___ FULL TIME ___ PART TIME
2. OTHER GUARDIAN: _______________________________________ RELATIONSHIP ____
3. OTHERS RESIDING IN HOME _______________________________________ RELATIONSHIP ____
4. DAYCARE/PRESCHOOL/SCHOOL: HOW MANY HOURS EACH DAY? ___________________ # DAYS OF THE WEEK? ___________
5. INTERACTION WITH RELATIVES: WHO? ____ HOW OFTEN? ____________________

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?____

DO YOU HAVE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS? PLEASE EXPLAIN.

____

____

ANY MISSED / RESCHEDULED APPOINTMENTS WITH LESS THAN 48 HOURS NOTICE WILL RESULT IN A CHARGE FOR THE FULL COST OF THE MISSED APPOINTMENT. PAYMENT FOR SERVICES, IE. CONSULTATIONS, LAB PROCEDURES AND MEDICAL THERAPY, IS DUE AT THE TIME SERVICE IS RENDERED.

I UNDERSTAND THE TERMS AND CONDITIONS AS STATED ABOVE. ***SIGNATURE:*** _________________________________