Pediatric History Form (Newborn - 16 years)

Welcome to Clearly Aligned! Chiropractic treatment does not cure any disease or treat symptoms alone. Our chiropractic analysis will focus on removing nervous system interference caused by physical, chemical, and/or emotional stressors, allowing the child's body to properly express health. To help us serve you better, please complete the following:

Name:_____
(Last) (First) (M.I.)
Address:_____
City:_____ State:_____ Zip: _____
D/O/B: _____ Age: _____ S.S.N.: _____
Sex: _____ Weight: _____ Height: _____Referred to our office by: _____

Name of Mother:_____ Name of Father:_____
Cell Phone:_____ Cell Phone:_____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone:_____
Legal Guardian(s) (If other than the parent): _____

Current Condition:
Purpose for this visit:_____
Other doctors seen for this condition:_____
Other health problems: _____
Do you feel your child's present diet, environment, and/or physical activity level related to his/her present health challenge? Yes/No.

If yes, please explain:_____

Doctor's visit or Hospitalization for the current condition? Yes/No. If yes, please fill out below:
Date:_____ Where:_____ Treatment
Given:_____ What other treatment options have you attempted to improve the condition?_____

How long has this condition been bothering your child?

(___) 1 week (___) 2-7 weeks (___) 2-4 months (___) greater than 4 months

How often does this condition bother your child? (Daily/Weekly/Monthly)_____

Has your child ever had similar conditions in the past? Yes/No. If yes, when:_____

This condition is (check one): (__)Getting worse (__)Staying the same (__)Improving

Do any particular activities or movements (standing, sitting, lying down, bending, twisting, lifting, walking, etc.) aggravate the condition?
_____

Is this condition interfering with: (__) School (__) Sleep (__) Concentration (__) Daily Routine

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health:

_____

Current Habits:

Please check any of the below habits that you child has:

(__) Junk Food (__) Healthy Foods (__) High Level of Activity/Exercise (__) Stress (__) Lack of Focus (__) Smoking (__) Drinking Alcohol (__) Soda/High Sugar Fruit Drink Intake (__) Low Level of Activity/Exercise (__) Difficulty in School (__) Excessive Television/Computer/Video Game use

Health History:

Check any of the following conditions your child has suffered from during the past six months:

- ❑ Ear infections_____
- ❑ Asthma/Allergy_____
- ❑ Colic_____
- ❑ Bed Wetting_____
- ❑ Scoliosis_____
- ❑ Digestive Problems_____
- ❑ Seizures/Epilepsy_____
- ❑ ADHD/Trouble focusing (explain)_____
- ❑ Chronic Colds_____
- ❑ Temper Tantrums_____
- ❑ Headaches/Migraines_____
- ❑ Growing Pains_____
- ❑ Recurring Fevers_____
- ❑ Other_____

Previous Chiropractor:_____ Last Visit:____/____/____
Reason: _____
Are you satisfied with the care your child has received? Yes/No
Family Doctor/Pediatrician? _____Date of Last Visit: ____/____/____
Reason:_____
List any medications, herbs, or additional remedies that your child has taken or is currently taking (please include how long each of these have been used): _____
_____
_____
Number of Doses of Antibiotics your child has taken:
In the past 6 months: _____ Total during his/her Lifetime: _____
Has your child been vaccinated? Yes/No_____
If No, do you plan on vaccinating your child? Yes/No_____
Did you notice any problems or changes after the vaccination? Yes/No
If yes, please explain: _____
_____

Prenatal History:

Name of OBGYN/Midwife:_____
Please list any complications during the pregnancy: _____
_____
How many ultrasounds did you receive during your pregnancy? _____
Did you smoke, drink, or use drugs during your pregnancy? _____

Please check all of the interventions used during the birth of your child:

- ❑ Forceps
- ❑ C-Section
- ❑ Epidural
- ❑ Vacuum Extraction
- ❑ Induced Labor
- ❑ Other_____

Please list any complications during delivery: _____
_____
Birth weight: _____ Birth length: _____ APGAR score: _____
Was your child born with any genetic disorders/disabilities? _____
_____
Was your child breast-fed or bottle-fed (how long)? _____
When was your child introduced to solid food? _____
Are you aware of any food allergies? _____

Developmental History:

Would you consider your child to be developing at a “normal” rate? Yes/No
If no, please explain: _____
According to the National Safety Council, 50% of children fall head-first. Has this happened to your knowledge? Yes/No_____

_____

Please list any impact sports that your child is/has been involved in (soccer, football, gymnastics, trampoline, cheerleading, diving, etc.): _____

_____

Please list any car accidents, emergency room visits, surgeries, traumas, concussions, illnesses etc. that your child has been through: _____

_____

Has your child had:

- ❑ Chicken pox
- ❑ Rubella
- ❑ Rubeola
- ❑ Mumps
- ❑ Whooping cough
- ❑ Other _____

Patient Informed Consent and authorization for treatment:

I, _____the undersigning parent/guarding having legal custody/ guardianship of - _____, a minor, do hereby authorize, request and direct Dr. Cori Seyhoon and whomever she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: _____ Signature: _____

Print Name Parent / Legal guardian