PEDIATRIC HEALTH RECORD

LONG CHIROPRACTIC CENTER
Get back to you

TODAY'S DATE _____ NEW PATIENT _____ REACTIVE _____

ABOUT YOUR CHILD

Name _____

Birthdate _____ Sex M ____ F ____

SSN _____

Address _____

City _____ State _____ Zip _____

Mother's Name _____

Mother's Address _____

City _____ State _____ Zip _____

Ph _____ Cell _____

Email _____

Father's Name _____

Father's Address _____

City _____ State _____ Zip _____

Ph _____ Cell _____

Email _____

Emergency Contact Name _____

Ph _____

Relationship _____

Was your child referred to us _____

Has your child had Chiropractice care before? Y N (circle one)

If yes, Doctor/Clinic _____

ETHNICITY ____ Hispanic ____ Non-Hispanic

RACE ____ Alaska Native ____ Asian ____ Native Hawaiian

____ White/Caucasian ____ American Indian ____ Black/African American

____ Other Pacific Islander ____ Other: _____

DID YOU KNOW...

Chiropractors work with the nervous system? Y / N

The nervous system controls all bodily functions & systems? Y / N

Chiropractic is the largest natural healing profession in the world? Y / N

HEALTH HABITS

Allergies: ____ None ____ Yes (list below)

Drugs/Meds _____

Food(s) _____

Other _____

Current RX medications ____ None ____ Yes (list below)

_____

_____

Any past surgies (dates): _____

_____

Any past accidents (dates): _____

_____

Any past injuries (dates): _____

_____

Is your child under the care of any other doctor? Y N (circle one)

Name(s): _____

SOCIAL HEALTH HISTORY

Recreational activities/hobbies _____

_____

Does your child consume caffeine? Y N (circle one)

How much _____ How often _____

FAMILY HEALTH HISTORY

	Cancer	Heart Disease	Arthritis	Diabetes
Siblings	___	___	___	___
Mother	___	___	___	___
Father	___	___	___	___

REASON FOR THIS VISIT

Symptoms _____

Date symptoms began _____

How did it occur? _____

Do you have recent X-rays of area? Y N (circle one)

If yes, facility where taken _____

CLINIC USE ONLY (Vitals age 2+ years)

Height _____ Inches; Weight _____ lbs.; Pulse _____ ; Respir _____ ; Temp _____ ;

Blood pressure (left arm/right arm) _____ / _____ (sitting / standing / supine) **Staff initials** _____

HEALTH HISTORY (cont.)

Was the child's delivery: ___ On time ___ Early ___ Late

Was the delivery ___ Vaginal ___ Cesarean (c-section)

___ At home ___ Hospital How long was labor: _____

Name of Dr. _____

APGAR score: _____/10 at birth _____/10 five minutes after birth

Were extraction aids used? (forceps/suction) _____

Was there more than one fetus? _____

Did the mother use alcohol or smoke during pregnancy? ___ Y ___ N

Was the child vaccinated? ___ Y ___ N Adverse reactions? _____

Is/was the child breatfed ___ Y ___ N Difficulties?_____

Did/does child use formula? ___Y ___N Allergies _____

Preferred side or head position for sleep _____

Difficulties meeting developmental milestones _____

Recent loss of appetite or change in eating habits _____

Recent change in bathroom habits _____

Any change in sleeping habits _____

Preferred sleeping position in bed _____

Any bumps, scrapes, cuts_____

Any recent fevers of unknown origins_____

HEALTH INVENTORY

Please circle the concern or condition you have now or have had in the past. Each concern relates to an area of the spine and nerve function.

Headaches
Migranes
Dizziness
C1 Sinus problems
C2 Allergies
C3 Fatigue
C4 Head colds
Vision problems
Difficulty concentrating
Hearing problems
Anxiety
Depression

Thyroid
Sore throat
Stiff neck
C5 Radiating arm pain
C6 Hand/finger numbness
C7 Asthma
T1 Allergies
High blood pressure
Heart conditions
Eczema

T2 Middle back pain
T3 congestion
T4 Difficulty breathing
T5 Bronchitis
T6 Pneumonia
T7 Gallbladder conditions
T8 Stomach problems
T9 Ulcers
T10 Gastritis
T11 Kidney problems
T12

L1 Constipation
L2 Colitis
L3 Diarrhea
L4 Gas pain
L5 Irritable bowel
S Bladder problems
A Menstrual problems
C Low back pain
R Pain or numbness in legs
A Reproductive problems
L

PRESENT ILLNESS / INJURY

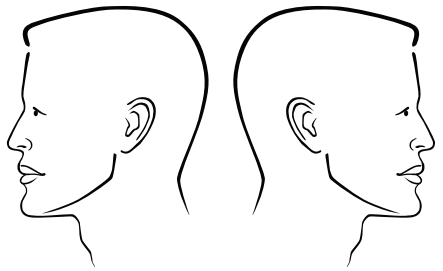
Please mark the activities with appropriate letter: **P** Painful **N** Normal **L** Limited

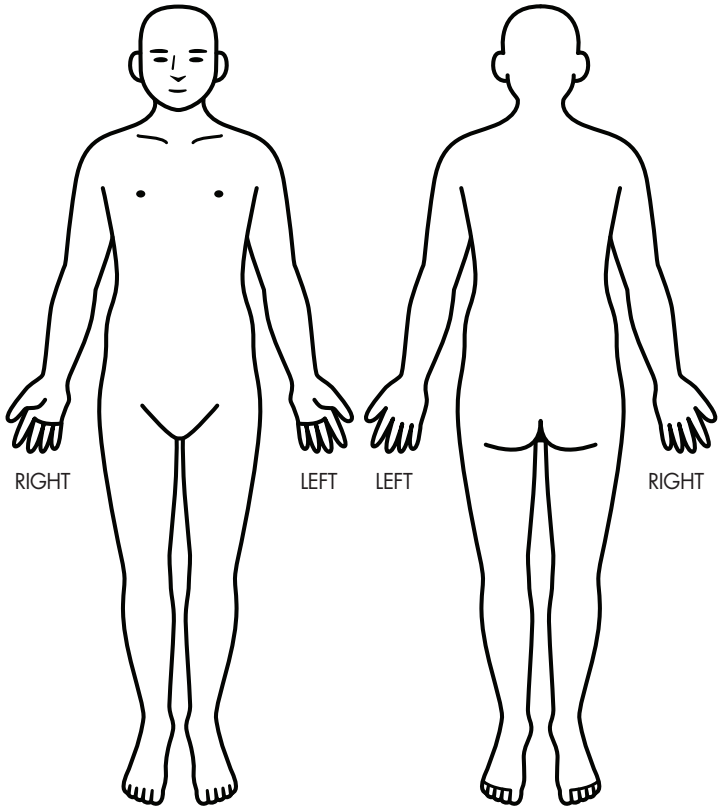
___ Lying on back	___ Pushing/pulling	___ Kneeling
___ Lying on sides	___ Reaching	___ Walking
___ Lying on stomach	___ Dressing self	___ Standing
___ Turning over in bed	___ Lifting	___ Bending forward
___ Stooping	___ Getting in/out of car	___ Cough/sneeze/grunt
___ Using stairs/ladder	___ Sitting/riding	
___ Gripping	___ Using a computer	

PRESENT ILLNESS/INJURY

Please mark the diagram below:

X X X BURNING PAIN
((((ACHING PAIN
- - - - - NUMBNESS
: : : : SHARP PAIN





PAIN SCALE

Please circle your current pain level: