

Child History Form

Date : _____ Child's Name: _____ () M () F DOB: _____ Age: _____

Mother: _____ Father: _____ Legal Guardian: _____

Best Phone: _____ () cell () Home SS NO.: _____ - _____ - _____

Address: _____ City: _____ Zip: _____

Email Address: _____@_____.com

Email or Text me appointment reminders: IF different # or email from above: _____

Cell Phone Provider (required for text reminders): _____

Who can we thank for referring you? _____

Pediatrician Name: _____ Last Appt Date: _____

Siblings? Names/ages: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____

What is your main reason for today's visit? () Wellness Check - FYI: INSURANCE MAY DENY if no musculoskeletal issues

() Other: _____

List any other care your child has undergone with regard to this complaint including medications:

Date of onset (mm/yyyy): _____ Onset was: () Sudden () Gradual () Associated with an event

Duration of problem/episode: (Check one) Pattern of Problem: (Check one)
____ () Minutes () Hours () Days () Months () Years () Constant () Intermittent () Occasional () Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body function and daily activities?

Prior occurrence or episodes? _____

Other health concerns? _____

Any known allergies? _____

HISTORY OF BIRTH

() Hospital () Birthing Center () Home () MD/DO () Midwife

Duration of Pregnancy: ____ Weeks Birth Weight _____ Birth Length _____ Hours in labor: _____

Was the birth assisted? () Yes () No If yes, how? () Forceps () Vacuum extraction () C-Section () Induced Labor

Were medications given to the mother at birth? () Yes () No If yes, what? _____

Was the delivery 'normal'? () Yes () No If no, what were the complications? _____

Birth Position: () Head first () Breech () Other: _____ APGAR at Birth ___/10 & after 5 minutes ___/10 UNKNOWN

GROWTH AND DEVELOPMENT

Was the infant alert & responsive within 12 hours of delivery? () Yes () No If no, explain _____

Are there any apparent delays? _____

Are there any suspected delays? _____

Sleeps on his/her-choose all that apply: () Back () Stomach () Right side () Left Side () Both sides () Incline () Unknown

Describe any health problems that exist on the mother &/or fathers side of the family? (i.e. cancer, diabetes etc.)

Do the child's siblings have any health problems? () Yes () No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

CHEMICAL STRESSORS

During pregnancy, did the mother: 1. Smoke () Yes () No 2. Drink alcohol? () Yes () No 3. Drink caffeine? () Yes () No

4. Take Rx/supplements? () Yes () No If yes, what? _____ 5. Become ill? If so, how? _____

6. Receive ultrasounds? () Yes () No If yes, how many? _____ 7. Receive invasive procedures (i.e. amniocentesis, CVS)? () Yes () No

8. Did Mother exercise during pregnancy? () No () Yes 9. Was/IS your child breastfed? () No () Yes, for how long? _____

At what age was: Formula introduced? _____ Brand? _____ Cows milk? _____ yrs/mos Solid foods? _____ yrs/mos

Did your child receive vaccinations? () Yes () No if yes, which ones? _____ Did your child react to them? () Yes () No

Has your child had antibiotics? () Yes () No If yes, how many & why? _____

Any pets at home? () Yes () No Any smokers at home? () Yes () No Childhood illnesses? () Yes () No _____

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? () Yes () No Any problems bonding? () Yes () No Avg # hours of TV/electronics per week _____ hrs

Any behavioral concerns? () Yes () No if yes, explain _____

Does your child have difficulties sleeping? () Yes () No If yes, explain: _____

TRAUMATIC STRESSORS

Any evidence of trauma during birth? () Bruises () Odd shaped head () Stuck in birth canal () Fast &/or excessively long birth () respiratory depression () cord around neck () other _____

Any falls/accidents during pregnancy? () Yes () No Has the child had any major falls since birth () Yes () No If yes, did the child need stitches or obtain a fracture? Describe: _____

Any hospitalization's? () Yes () No Please explain: _____

Is your child involved in any activities (Yoga; Tumbling, etc)? () Yes () No # Hrs/week? _____ Age child began _____

Signature of Parent or guardian: _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name:** _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ **Date:** _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Temp: _____ Pulse: _____

Developmental Milestones

Date: _____

Name: _____ DOB: _____ Age: _____ M / F

GROSS MOTOR SKILLS

- 4 wks Able to hold head up from the table momentarily
- 3 mths Head and shoulder can be supported by forearms
- 4 mths Infant can be pulled up into sit position by the hands
- 6 mths Sits unsupported in the upright position
- 6 mths Head and shoulders can be supported by the arms
- 6 mths Rolls from a face down to a face up position
- 9 mths Crawls
- 9 mths Stands holding onto furniture
- 11 mths Walks with someone holding onto one hand
- 12 mths Walks unassisted
- 2 years Runs
- 2 years Negotiates stairs placing 2 feet on each step
- 3 years Climbs stairs using one foot on each step
- 4 years Walks downstairs with one foot on each step
- 4 years Hops on one foot

SOCIAL SKILLS

- 2 mths Smiles
- 3 mths Reaches for familiar objects
- 4 mths Plays with hands
- 6 mths Plays with feet
- 9 mths Clearly shows joy and pleasure
- 12 mths Feeds self with fingers
- 15 mths Plays peek-a-boo
- 18 mths Understands yes and no

FINE MOTOR SKILLS

- At birth Primitive grasp reflex present
- 4 mths Holds & shakes a rattle placed in hand
- 5 mths Grasps objects independently
- 6 mths Moves an object from 1 hand to other
- 6 mths Self-feeding, can hold & eat a cookie
- 6 mths Checks objects by placing them in Mouth
- 12 mths Picks up object w/ thumb & index Finger
- 15 mths Turns 2-3 pages of a book at a time
- 18 mths Turns pages of a book 1 at a time
- 24 mths Builds a tower containing at least 5 blocks
- 4 years Builds a tower containing at least 10 blocks

COMMUNICATION SKILLS

- 7 wks Makes cooing sounds
- 3 mths Laughs
- 5 mths Uses one syllable words, i.e. "da"
- 8 mths Uses 2 syllable words, i.e. "dada"
- 12 mths Uses 2 – 3 word vocabulary
- 24 mths Uses 2 – 3 word phrases

ADAPTIVE SKILLS

- 10 mths Feeds from a cup unassisted
- 12 mths Holds own bottle
- 30 mths Feeds self with utensils
- 30 mths Able to identify and match some colors
- 36 mths Copies a circle
- 42 mths Copies a cross

PARENT SIGNATURE: _____

Date: _____