Child History Form

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

Mother: _____ Father: _____ Legal Guardian: _____

Best Phone: _____ ( ) Cell ( ) Home Alt Phone #:_____ ( ) Cell ( ) Home

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)
____ ( ) Minutes ( ) Hours ( ) Days ( ) Months ( ) Years

Pattern of Problem: (Check one)
( ) 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 ( ) Now If no, what were the complications? _____

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

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:_____

Temp:_____

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: _____