Pediatric Health History

Great Lakes Chiropractic
13601 80th Circle N. Suite 210
Maple Grove, MN 55369

Date: __________________ Child's Name: ____

SS# of Guardian (please indicate father/mother): ____

DOB: ____________ Age: ____ Grade In School: ______ Sex: _____ Home Phone: _____________________

Address: _______________________________ City: _______________________ State: _____ Zip: ________

Mother's Name: _______________________________ Cell/Work Phone: _______________/_______________
First **Last**

Father's Name: _______________________________ Cell/Work Phone: _______________/_______________
First **Last**

Purpose of this appointment: ____
____
____

Pregnancy History (Mother)
(If the child is adopted, answer to the best of your ability)
Did you ever experience any of the following during your pregnancy:

___ Severe viral infection during the first trimester
___ Breech position during pregnancy
___ Accident or infections
___ Smoking
___ Severe stress
___ Pre-eclampsia
___ Alcohol consumption and/or drug use
___ Radiation exposure
___ Hypertension (high blood pressure)
___ Toxoplasmosis
___ Uncontrolled Diabetes
___ Toxemia

Labor and Delivery History
Did you and/or the child experience any of the following during the labor/delivery:

___ Hospital birth
___ Birthing home
___ Long and/or difficult labor
___ Placenta previa
___ Forceps or vacuum
___ Fetal distress
___ Elective c-section
___ The child was a "blue baby"
___ Home birth
___ The labor was induced
___ The delivery was rapid
___ Breech birth
___ Cord around neck
___ Emergency c-section
___ The child was premature (2+ weeks)
___ Medications during delivery. If yes, list (i.e. epidural)________________
____

Comments:____
____
____

Pediatric Health History

Newborn History
Did the child experience any of the following as a newborn:

___ Required resuscitation/oxygen
___ Jaundice
___ Poor sleeper
___ Colic
___ Immunizations in hospital
If yes, specify vaccine:

___ Distorted skull
___ Difficulty latching/sucking
___ Formula fed
___ Breast fed (___ breast or ___ bottle)
If breast fed, how long _____________

Weight at birth: __________ Length at birth: __________

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

___ Illness accompanied by a high fever
___ Headaches (occasional or frequent)
___ Seizures/Convulsions
___ Ear infections/earaches (if so, how many) ___________
___ Head injury
___ Serious fall(s) or repetitive falls
___ Epilepsy
___ Meningitis
___ Allergies to foods
___ Environmental allergies
___ Chemical insensitivities
___ Neck or back problems
___ Rheumatic Fever
___ Is child vaccinated?
___ Have you declined any vaccines?
___ Adverse reaction to any vaccinations (even if mild)
If yes, please explain:
____
____

___ Dizziness
___ Diabetes
___ Hypoglycemia (low blood sugar)
___ Trouble with bladder control
___ Fainting
___ High blood pressure
___ Heart Disease
___ Asthma
___ Sinus problems
___ Constipation
___ Digestive disorders
___ Joint or muscle problems
___ Undergone any surgeries
If yes, please explain:
____
____
____

Developmental History
Does your child have any of the following:

___ Difficulty with crawling (on all fours)
___ Difficulty learning to ride a bike
___ Difficulty learning to read
___ Difficulty using utensils
___ Difficulty tying shoes
___ Poor hand-eye coordination

___ Did not crawl on all fours
___ Appears clumsy
___ Difficulty with writing
___ Difficulty buttoning clothing
___ Difficulty or awkward with walking/running
___ Difficulty sitting still or paying attention

Age of child when he/she sat _______ crawled _______
How long did your child crawl (in months): _________________
At what age did your child start to walk unassisted: ___________

Comments:____
____

Pediatric Health History

Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

___ Hearing loss or impairment
___ Neurological disorders
___ Obsessive Compulsive Disorder (OCD)
___ ADD/ADHD
___ Dyslexia
___ Visual impairment
___ Anxiety/Depression
___ Autism/Autism Spectrum Disorder
___ Tourette's Syndrome
___ Other___________________________

Current/Past Medications and Treatment

List any medications that your child is taking or has taken in the past:
List names, dosage, frequency
____
____

List any supplements your child takes:
____
____

List any special services that your child is currently receiving at school or privately:
____
____

List any special needs your child has:
____
____
____

List any treatment that your child is currently undergoing with any health professional:
____
____

List any previous chiropractic treatment:
____
____

Family History:

Unwanted health condition of mother/father? ____
Sibling Names and Ages: ____
Has child been treated or currently being treated for any health concern? ________________________________
____
____

Authorization for Care of a Minor

I hereby authorize Dr.______________________________D.C. to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as soon as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

Patient Health Information

The patient understands and agrees to allow Great Lakes Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

____ ______________________
Signature and relation of person completing this form **Date**

____ ______________________
Signature of a witness **Date**