

SCHARENBERG CHIROPRACTIC OFFICES

PEDIATRIC HEALTH HISTORY

Patient Name _____ Nick Name _____ Date _____
SS# _____ Birth Date _____ Sex M F Name of Parents/Guardians _____
Address City State Zip _____
Home Phone _____ Parent's Work Phone _____ Cell Phone _____
Email Address _____ Referred by _____

Consultation

Reason for seeking chiropractic care: _____
When did the problem begin? _____
Is this problem Occasional Frequent Constant Intermittent Other _____
Does the problem radiate? No Yes If yes, where? _____
What makes it worse? _____
What makes it better? _____
Is the problem worse during a certain time of the day? No Yes If YES, when? _____
Does this interfere with the child's Sleep Eating Daily routine? Is this becoming worse? No Yes
If yes, how? _____
Other professionals seen for this condition? _____
Results with treatment? _____

Prenatal History

Name of Obstetrician/Midwife _____
Complications during pregnancy: No Yes List: _____
Ultrasounds during pregnancy: No Yes How Many: _____
Location of Birth: Hospital Birthing Center Home
Birth intervention: Forceps Vacuum Caesarian: Planned or Emergency
Complications during delivery: No Yes _____
Medications during pregnancy: No Yes List: _____
Medications during delivery: No Yes List: _____
Cigarette / Alcohol use during pregnancy: No Yes
Was the infant alert and responsive within 12 hours of delivery? No Yes
If No, please explain _____
Birth weight _____ Birth length _____ APGAR scores _____
Genetic disorders or disabilities? _____
Breast Fed: No Yes How long? _____ Formula fed: No Yes How long? _____
Solids at _____ months Cow's milk at _____ months Food/juice allergies or intolerances No Yes
Anything else that needs to be noted: _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold head up _____
Vocalize _____ Sit alone _____ Crawl _____ Walk _____ Sleep Through Night _____
Do you consider your child's sleeping pattern normal? No Yes Number of hours sleeping per night _____

Medication History

Previous Chiropractor: _____ Date of last visit & Reason: _____
Name of Pediatrician: _____ Date of last visit & Reason: _____

Are you satisfied with the care your child received there? Yes No
Immunization history: _____
Reactions: _____
Check all drugs your child is taking including prescription and non-prescription drug
 Asthma medication Tylenol Advil/Ibuprofen Cold tablets Allergy Med
 ADHD Med Painkillers Anti-Depressants Other _____
Does your child take any Vitamins or Herbs? No Yes _____
Number of antibiotics your child has taken: Past 6 months _____ Total during his/her lifetime _____

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Falls & Injuries

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.).

Is this the case with your child? No Yes

When was your child's most recent fall? _____ What happened? _____

Which of the following sports have your child been involved in?

Football Basketball Soccer Gymnastics/Cheerleading Martial Arts
 Running Horseback riding Other: _____

Has your child ever broken a bone if so, which one? _____

Has your child ever been involved in an auto accident? No Yes Was there impact? No Yes

Were there injuries? No Yes (Dates/any treatment) _____

Has your child ever been seen on an emergency basis? No Yes (please list all) _____

Other traumas not described above? No Yes _____

Prior surgery: No Yes If yes, Type and Date: _____ Menses: No Yes Age: _____

Childhood Diseases & Illness

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autism	<input type="checkbox"/> Backaches
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Car Accident	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Chronic Colds
<input type="checkbox"/> Chronic Earaches	<input type="checkbox"/> Colic	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fainting
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Hernias	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pains
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor Coordination	<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Rubella
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Sinus
<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Walking Problems	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Other: _____	

Authorization To Treat A Minor

I _____, Parent or legal Guardian of _____
YOUR NAME (PRINT) CHILD'S NAME

Hereby authorize D.R. Scharenberg, D.C. and his staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of Parent/Guardian _____ Date _____