Westwood Family
Chiropractic

Pediatric Health History

PATIENT INFORMATION

Full Name: ______________________________________ ☐Male ☐Female Date: ___________
Date of Birth: __________________ Age: ____________ Ht.________ Wt. ________
Home Address: ____ City: ___________ State: _____ Zip: __________

CONTACT INFORMATION

Parent's name(s): ____ Home Phone #:___________________
Parent #1 Cell Phone #: ______________________ Parent #1 Email:_______________________________________
Parent #2 Cell Phone #: ______________________ Parent #2 Email:_______________________________________
Emergency Contact Name and Number: ____
How did you hear about the doctor? If someone referred you, who can we thank?___________________________

HEALTH PROFILE

Please check reasons for pursuing chiropractic care for your child

☐My child is continuing ongoing care from another chiropractor

☐I recently had my spine checked and I see the value in getting my child checked

☐I'm concerned about my child's health and I'm looking of answers

☐I want to improve my child's immune function

☐I have no idea why we are here. Please take the time to explain to me what you do for children

☐My child has a specific condition that concerns me. Explain: ____

In order for us to better understand your child's current level of health, Please check any of the following body signals which your child has or has had previously. Check all that apply.

☐Headaches
☐Car accident
☐Colic
☐Other____________________________________
☐Postural Imbalance
☐Sinus problems
☐Frequent colds
☐ Asthma
☐Allergies
☐Autism
☐Ear infections
☐Growing pains
☐Digestive problems
☐Scoliosis
☐Seizures
☐ADD/ADHD
☐Bedwetting

HEALTH HISTORY

Has your child ever seen a chiropractor before? ☐ YES ☐ NO If yes, approximate last date adjusted:_______________

Names of other doctors who have cared for your child:_______________

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan:_______________

Medications your child is taking:_______________

Supplements you child is taking:_______________

Number of rounds of Antibiotics taken: During the last 6 months_________ In Lifetime__________

Reasons:_______________

Number of rounds of other prescription medications taken: During the last 6 months________ In Lifetime________

Reasons:_______________

Vaccine History:_______________

PARENTAL HISTORY

Adopted: ☐ YES ☐ NO

Complications during pregnancy: ☐ YES ☐ NO If yes, explain:_______________

Complications during delivery: ☐ YES ☐NO If yes, explain_______________

Birth interventions:

☐Mother medicated (Pitocin,epidural, etc.) ☐Cesarean section ☐ Vacuum extraction ☐ Forceps

☐Emergency genetic disorders ☐ Vacuum extraction ☐ Other_______________

TRAUMA HISTORY

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

Was this the case with your child? ☐ YES ☐NO If yes, explain:_______________

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? ☐ YES ☐ NO If yes, List:_______________

Has your child ever had surgery? ☐YES ☐ NO If yes, explain:_______________

Has your child ever been involved in a car collision? ☐YES ☐NO If yes, explain:_______________

Other traumas not described above:_______________

The statements made on this form are accurate to the best of my knowledge.

Signature ______________________________ ***Date*** ______________________