PERSONAL & FAMILY HEALTH HISTORY - CHILD

1. Personal Information

Date: ______/______/____________

Name: _________________________________

Home Address:

____

____

____

City: _____________________ State: ________

Zip Code: ____________

Phone Numbers:

Home: (_____) _____________________

Mobile: (_____) ____________________

Please notify us if you **DO NOT want to receive text message appointment reminders.*

Date of Birth: ______/______/____________

Age: ________

Parent or Legal Guardian Name(s): ______________

____

Emergency Contact: __________________________

Emergency Phone: (_____) ___________________

How Did You Find Out About Us? _______________

____

Referred By: _________________________________

____

____

E-mail: ____________________________________

** We will **NOT** share your email with any third parties. We will only use your email to contact you in relation to your care with our practice.*

PERSONAL & FAMILY HEALTH HISTORY

Our Pledge to Protect Your Privacy

Eclipse Chiropractic knows that medical information about you is personal and is committed to protecting the privacy of your information. As a patient of this office, the care and treatment you receive is recorded in an electronic medical record. Upon electronic entry, all paper documents are destroyed. We share your information only to the extent necessary to conduct our business operations, to collect payment for the services we provide you and to comply with the state and federal laws that govern health care. We will not use or disclose your personal information for any other purpose without your written permission.

2. Current Health Condition

If You Are Only Here for Chiropractic Wellness Services, You Can Skip this Section

What Health Condition Brings Your Child into Our Office? ____

____

Please Try to Describe Your Child's Current Pain or Discomfort: __________________________________

____

When Did the Symptoms or Problem Begin? ____

How Did the Problem Start? ❒ Suddenly ❒ Gradually ❒ Post-Injury

Is This Condition… ❒ Getting Worse ❒ Improving ❒ Intermittent ❒ Constant ❒ Not Sure

Currently, His/Her Pain is…………………… ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent ❒ Debilitating

Select Frequency You Experience Pain from this Condition:

❒ Always ❒ Hourly ❒ Daily ❒ Occasionally ❒ Other ____

What Activities Aggravate Your Child's Condition or Pain? ____

____

Has your Child Had a Recent Injury? ❒ No ❒ Yes If Yes, Where Did the Injury Occur?

____

Date of Injury: ______/______/____________

What Activities Lessen His/Her Condition/Pain? ____

Is Condition Worse During Certain Times of the Day? ____

Is This Condition Interfering with Any of the Follow? ❒ School? ❒ Sleep? ❒ Routine?

❒ Other? ____

Is This Condition Getting Progressively Worse? ❒ No ❒ Yes

Other Doctors Seen for This Condition: ____

Does Your Child Eat Well? ❒ Yes ❒ No

Does Your Child Have Regular Bowel/Bladder Movements? ❒ Yes ❒ No

Has Your Child Ever Been Checked for Vertebral Subluxations? ❒ Yes ❒ No

PERSONAL & FAMILY HEALTH HISTORY

3. Health History

Child's Birth was… ❐ At Home ❐ At A Birthing Center ❐ At A Hospital ❐ Other

Child's Birth was… ❐ Natural Vaginal (No Medications or Interventions)
❐ Vaginal with Interventions ❐ Induction ❐ Pain Medications ❐ Epidural ❐ Episiotomy
❐ Vacuum Extraction ❐ Forceps ❐ Other ____

C-Section ❐ Yes ❐ No If Yes, Was It.. ❐ Scheduled ❐ Emergency

Please List Reasons for Any Interventions/Complications: ____________________________________

____

Child's Birth Weight: ________ Child's Birth Height: ________ Current Weight: ________

Current Height: ________ APGAR Score at Birth: ________ APGAR Score after 5 Minutes: ________

4. Growth and Development

Was Your Child Alert and Responsive Within 12 Hours of Delivery? ❐ Yes ❐ No

If No, Please Explain: ____

At What Age Did Your Child Do the Follow…

Respond to Sound: ______ Follow an Object: ______Hold Head Up: ______ Vocalize: ______

Sit Alone: ________ Teethe: ________ Crawl: ________ Walk: ________

Patient/Hospitalization/Surgical History (*Please List all Surgeries and Hospitalizations, Including Year*)

____

Please List Any Major Injuries, Accidents, Falls and/or Fractures Your Child Has Sustained in his/her Lifetime, Including Year: ____

____

Is/Was your Child Breastfed? ❐ Yes ❐ No If yes, How Long? ___________________

Formula Introduced at Age: _____________ What Type? ____________________

Introduction of Cow's Milk at Age: ________________ Began Solid Foods at Age: _______________

Please List any Foods/Juice Intolerance: ____

PERSONAL & FAMILY HEALTH HISTORY

Did Mother Smoke During Pregnancy? ❐ Yes ❐ No

Did Mother Drink Alcohol During Pregnancy? ❐ Yes ❐ No

Any Illness of Mother During Pregnancy? ❐ Yes ❐ No

If Yes, Please Explain Including Treatment/Medications/Supplements: ______________________________

____

List Any Drugs/Medications (*Including Over-the-Counter*) Taken During Pregnancy
____

____

List Any Supplements Taken During Pregnancy: ____

Any Exposures to Ultrasound? ❐ Yes ❐ No If So, How Many and What Was the Medical Reason?

____

Any Pets at Home? ❐ Yes ❐ No

Any Cigarette Smokers at Home? ❐ Yes ❐ No

Has Child Received any Vaccinations? ❐ Yes ❐ No

If yes, Which Ones and List any Reactions: ____

Has Child Received any antibiotics? ❐ Yes ❐ No If yes, How Many Times and List Reasons: __________

____

Any Difficulty with Breastfeeding? ❐ Yes ❐ No If Yes, Please Explain: _____________________________

____

Any Difficulty with Bonding? ❐ Yes ❐ No If Yes, Please Explain: _________________________________

____

Any Behavioral Problems? ❐ Yes ❐ No If Yes, Please Explain: ____________________________________

____

Any Night Terrors, Sleepwalking or Difficulty Sleeping? ❐ Yes ❐ No

If Yes, Please Explain: ____

PERSONAL & FAMILY HEALTH HISTORY

Age Child Began Daycare: _______________ Average Number of Hours of TV Per Week: _____________

Does Your Child Seem Normal for Their Age? ❒ Yes ❒ No

If No, Please Explain: ____

Have You had Previous Chiropractic Care? ❒ Yes ❒ No

Were you Pleased with Your Care? ❒ Yes ❒ No

Date of Last Visit: ______/______/___________

List Current Medications: ____

____

List Current Vitamins, Minerals, Supplements, or Herbs: _______________________________________

____

____

Please List any Allergies Your Child Has: ____

____

____

5. Personal Incident History

Broken Bones? ❒ Yes ❒ No

If Yes: Did You Get Professional Care?

❒ Yes ❒ No

Briefly Explain: ________________________

____

Been Struck Unconscious? ❒ Yes ❒ No

If Yes: Briefly Explain: __________________

Had Major Sprain or Strain? ❒ Yes ❒ No

If Yes: Briefly Explain: ___________________

____

Been in an Auto Accident? ❒ Yes ❒ No

If Yes: Briefly Explain: ___________________

____

____

PERSONAL & FAMILY HEALTH HISTORY

6. Other Symptoms

My Child is Currently Experiencing… (Please Check All That Apply)

- ❐ Headaches
- ❐ Neck Pain
- ❐ Sleeping Problems
- ❐ Back Pain
- ❐ Nervousness
- ❐ Tension
- ❐ Irritability
- ❐ Chest Pains
- ❐ Dizziness
- ❐ Face Flushed
- ❐ Neck Stiffness
- ❐ Pins & Needles in Legs
- ❐ Pins & Needles in Arms
- ❐ Numbness in Fingers
- ❐ Numbness in Toes
- ❐ Shortness of Breath
- ❐ Fatigue
- ❐ Depression
- ❐ Light Bothers Eyes
- ❐ Loss of Memory
- ❐ Ear(s) Ring
- ❐ Fever
- ❐ Fainting
- ❐ Cold Sweats
- ❐ Loss of Smell
- ❐ Loss of Taste
- ❐ Excess Stress
- ❐ Diarrhea
- ❐ Feet Cold
- ❐ Cold Hands
- ❐ Upset Stomach
- ❐ Constipation
- ❐ Loss of Balance
- ❐ Buzzing in Ears

7. Family History

Check Those Involving Immediate Family and Add Identification:
Identifiers: ***M*** *= Mother,* ***F*** *= Father,* ***S*** *= Siblings,* ***G*** *= Grandparent*

❐ Cancer, Type ___________________________
❐M ❐F ❐S ❐G

❐ Depression
❐M ❐F ❐S ❐G

❐Diabetes
❐M ❐F ❐S ❐G

❐Back Problem
❐M ❐F ❐S ❐G

❐ Heart Disease
❐M ❐F ❐S ❐G

❐ Liver Disease
❐M ❐F ❐S ❐G

❐High Blood Pressure
❐M ❐F ❐S ❐G

❐High Cholesterol
❐M ❐F ❐S ❐G

❐ Lung Problems
❐M ❐F ❐S ❐G

❐ Scoliosis
❐M ❐F ❐S ❐G

❐Neck Problems
❐M ❐F ❐S ❐G

❐Osteoporosis
❐M ❐F ❐S ❐G

❐ Seizures
❐M ❐F ❐S ❐G

❐ Osteoarthritis
❐M ❐F ❐S ❐G

❐Rheumatoid Arthritis
❐M ❐F ❐S ❐G

❐Sensory Processing Disorder
❐M ❐F ❐S ❐G

Other: ____

____

____

____

PERSONAL & FAMILY HEALTH HISTORY

Were You Aware That…

Do You Know What a Subluxation Is? ❒ Yes ❒ No

Do Any of Your Friends or Relatives See a Chiropractor? ❒ Yes ❒ No

If Yes, Do They Use Chiropractic For ❒ Health/Maintenance ❒ Health Problems ❒ Both

Are You Seeking Chiropractic For ❒ Health/Maintenance/Optimization ❒ Health Problems ❒ Both

What Would You Like to Gain from Chiropractic Care? ____

Are There Other Health Concerns or Anything Else You Would Like Us to Know About Your Child?
____

____

____

____

____
(Date)

____
(Signature)

____
(Print Name)

________________________________ ____________
(City) (State)

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