

VanNess



Chiropractic • Massage • Rehabilitation

Confidential Pediatric Health History

Today's Date: _____
Child's Name: _____ Sex: M F Date of Birth: _____ Age: _____
Parent's Names: _____ # of Siblings: _____
Address: _____ Phone: _____
Child's Pediatrician: _____ Phone: _____
Well-Child Visit: Y / N

Reason for today's visit: _____

Pregnancy History:

- What was the length of mother's pregnancy? _____
- Any trauma? _____
- Any systemic problems (i.e., diabetes, high blood pressure, indigestion, anemia, etc.)? _____
- Did you use any of the following during pregnancy? Alcohol, tobacco, prescription or non-prescription drugs _____
- Other pertinent information for the doctor: _____

Birth History:

- Birth: Hospital / Home Mid-Wife / OB Other: _____
- Delivery: Vaginal / Planned C-Section / Emerg. C-Section
- Epidural: Y / N Pain Meds: Y / N
- Was Baby Induced (Pitocin): Y / N
- Forceps or Vacuum extraction were used: Y / N
- Fetal Presentation: Head / Breech
- Was child active and crying within one minute of birth: Y / N
- Birth Weight: ___ lbs ___ oz. Birth Length: _____ inches
- Were vaccines administered at the hospital: Y / N
- How long was labor? _____
- Other pertinent information for the doctor: _____

Newborn, Infant & Early-Childhood History

- **Is/Was child breast-fed or formula-fed?** _____
If formula, which one? _____
- **Is child eating any solid foods? Y / N Which ones:** _____

- **Does child experience digestive problems? Y / N**
- **Does child have any food allergies? Y / N If yes, to which ones:** _____

- **What is the child's favorite food?** _____
- **Describe the child's sleep pattern:** _____

- **Does child favor sleeping/eating on one side? Y / N Right / Left**
- **Does child frequently cry? Y / N If yes, # of hours per day** _____
- **Is child vaccinated? Y / N If yes, date of last vaccine** _____
- **Has child experienced any trauma (car accidents, falls from changing table, sports injuries, etc.)? Y / N**
If yes, explain _____
- **Has child suffered from any childhood disorders (i.e., asthma, colic, ear infections, bowel problems, eczema or skin problems, torticollis, toe in/out, behavioral problems, scoliosis, headaches, or frequent colds)?**
Please describe in detail: _____

- **Are there any smokers or pets in the child's home? Y / N**
- **Has your child missed any milestones of normal development? Y / N**
If yes, please explain: _____

- **Does child have any vision, hearing or balance problems? Y / N**
If yes explain: _____
- **Have you noticed any problems with your child's posture? Y / N If yes explain:** _____
- **Does child take any medications or vitamin supplements? Y / N**
If yes, please list all: _____
- **Has child ever had any surgeries? Y / N List:** _____
- **What are the child's favorite activities?** _____
- **If child complains of back pains, is it more in the AM or PM?** _____
- **Has your child ever previously been under chiropractic care? Y / N**
- **Anything else that you would like to tell the doctor about your child:**

I give authorization for Dr. VanNess to evaluate and treat my child.

Parent/Guardian's Signature: _____

Today's Date: _____