PEDIATRIC CHIROPRACTIC HEALTH SCREENING

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stresses (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Child's Name:____

Age: ______________ Date of Birth: ______________________________

Parent's Name(s): ____

Occupations: ____

Address: ____
City State Zip

Phone Numbers: ____
Home Work Cell

Reason for Visit: ____

Did your child have any trauma during child birth? ______________________

Feeding:

Breast fed? Y N If yes, how long? __________

Intolerance or allergy to formula or foods? Y N If yes, what? ____________

Did you supplement the bottle with cereal? Y N If yes, at what age? _________

At what age did your child began eating solid foods? ______________

Does your child take vitamins or supplements? Y N

If yes, please list: ____

Developmental Milestones:

If known, at what age did your child:

Sit up ______ Sit up without support ______ Crawl ______ Walk ______

History: Problems While Newborn

1. **Jaundice** Yes No
2. **Infections** Yes No
3. **Colic** Yes No
4. **Breathing Problems** Yes No
5. **Feeding Problems** Yes No

Please Explain any Yes answers for the Newborn time period or any problems your child experienced while a newborn that are not listed:

____

____

____

Past History:

According to the National Safety Council, approximately 50% of infants fall from a high place (bed, couch, etc.) during their first year of life.

Has your child fallen from a high place? Y N

Has your child been in a motor vehicle accident of any kind? Y N

If yes, please explain: ____
____

Has your child had any type of surgery? Y N

Description: _______________________ Date: ______________________________
_______________________ ______________________________

Has your child been seen by either a doctor or hospital on an emergency basis? Y N

Reason: ____

Does your child have any learning challenges? Y N

What Kind/Type? ____

Please place a mark to indicate if your child has had any of the following:

______ Chicken Pox ______ Rubella ______ Measles ______ Roseola

______ 5ths Disease ______ Whooping Cough ______ Other

Current or Past Conditions:

Check any of the following that your child has had within the past 12 months:

___ Ear Infection	___ Asthma	___ Eczema	___Visual Impairment
___ Recurring fevers	___ Digestive Problems	___ Temper Tantrums	___ Growing Pains
___ Scoliosis	___ Allergy	___ Psoriasis	___ Colic
___ Seizures	___ Back Discomfort	___ ADD	___ Diabetes
___Bed Wetting	___ Headache	___ Chronic Cold	___ADHD
___ Subluxation	Other ________________		

Medications:

Is your child allergic to any medications? Y N Please list: ____________________________

Does your child have any other allergies? ____
____
____

How many prescriptions of antibiotics has your child taken in the past 12 months? __________

How many other prescriptions has your child taken in the past 12 months? _________________

Reasons for taking prescriptions: _______________________________________

How many over the counter medications has your child taken in the past 12 months?__________

What types: ____

Is your child currently taking medications (prescription or non-prescription)? Y N

If so, what kind? ____

Immunizations:

Has your child been immunized? Y N

Has your child had any allergic reactions to immunizations, including fever, irritability, rash, loss of appetite, change in behavior, or loss of sleep? Y N What type? ______________

Consent to Treatment for a Minor/Child:

As of today's date, I have the legal right to select and authorize health care service for the minor child named below. The consent of a spouse, former spouse or other parent is not required. If my legal authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. I hereby authorize Dr. Hextell to examine and provide chiropractic care for my child.

Child's Name (Printed): ________________________________ Date of Birth:________________

Your Relationship to the Chid:____

Legibly Printed Parent/Guardian Name: ____

Signature: ____ Date: ________________

Parent or Guardian