

EXODUS HEALTH CENTER

Dr. David Jockers/ Dr. Shannon Good/ Dr. Andrew St. Bernard

INDIVIDUALIZED PEDIATRIC HISTORY FORM

IT'S ALL ABOUT THE UNIQUENESS OF YOUR CHILD

PATIENT DEMOGRAPHICS

HR#: _____

Childs Name _____ Today's Date ____/____/____

Date of Birth ____/____/____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____ Mother's Mobile _____ DOB ____/____/____

Fathers name: _____ Father's Mobile _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____

Last Visit: ____/____/____ Reason for visit: _____

Who is responsible for this bill? _____

Other (please explain): _____

Purpose of this visit: ____Wellness Check ____Injury or Accident ____Other Health Challenge

1. **If your child is experiencing Pain/Discomfort/health challenges please identify what, where and for how long (when did you first notice this sign of body dysfunction? Date ____/____/____)**

Has your Child **Ever had** this problem **before**? _____NO _____YES

If yes when? _____

What do you feel is the cause of your child's problem?

How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same
 Gradually Worsening On & Off

Why do you think so?

What are the most significant measures you have taken to date to improve your child's present health challenge?

Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

2. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain

3. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

HAS YOUR CHILD EVER SUFFERED FROM: CHECK ALL THAT APPLY

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADH | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Chronic Earaches |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib |
| <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair |
| <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs | <input type="checkbox"/> Fall from changing table |
| <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____ |

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Number of doses of antibiotics has your child taken: _____ in the past 6 months _____ in his/her lifetime

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

Vaccination History: _____

PRENATAL HISTORY:

Type of birth attendant: OBGYN CNM LAY MIDWIFE

Name of Attendant: _____

Location of birth: _____ Home Birthing Center Hospital

Complications During Pregnancy: NO YES List: _____

Ultra Sounds During Pregnancy: _____ NO YES Number: _____

Medications During Pregnancy/ Delivery: _____ NO YES LIST: _____

Birth Intervention: ____ Forceps ____ Vacuum ____ Caesarian: Planned or Emergency

Complications during Delivery: NO YES LIST: _____

Genetic Disorders or disabilities: NO YES LIST: _____

Cigarette or Alcohol Use during Pregnancy: _____ NO YES

Birth Weight _____ Birth Length _____ APGAR score _____

FEEDING HISTORY:

Breast fed: _____ NO YES How long? _____

Formula Fed: _____ NO YES How long? _____

Type of formula: _____

Introduced to solids at _____ Months, Type: _____

Cow's Milk at _____ Months

DEVELOPMENTAL HISTORY:

Number of hours of sleep/ night: _____

Quality of sleep: GOOD FAIR POOR

At what age was your child able to:

_____ Respond to sound _____ Cross Crawl

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Hold Head up _____ Walk alone

_____ Sit Up

CHILDHOOD DISEASES:

Chicken Pox: NO/YES AGE: _____ **Mumps:** NO/YES AGE: _____

Rubella: NO/YES AGE: _____ **Whooping Cough:** NO/YES AGE: _____

Rubeola: NO/YES AGE: _____ **Other:** _____ NO/YES AGE: _____

According to the National Safety Council, Approximately 50% of all children Fall head first from a high place during their first year of life (ie: a Bed , changing table, down stairs, etc) Was this the case with your Child? ___ No ___ Yes

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemical? ___ Yes
___ No

If yes, for what reason and for how long?

Has your child ever been hospitalized? ___ Yes ___ No
If yes, why and when? (Please list in chronological order)

I understand that I am directly and fully responsible to **EXODUS HEALTH CENTER** for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date _____

Doctor Signature _____

Date _____