GLEASON FAMILY
CHIROPRACTIC

Pediatric Health History form: Today's Date_____

Child's First Name:_____ Middle:_____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Father's Name: _____

Mother's Phone #: _____ Father's Phone #: _____

Email: _____

Child's Birth Date: _____ Male/Female (circle one)

Reason for consulting our office?: _____

Whom may we thank for referring you?: _____

Pediatrician/Family MD: _____

May we contact them (circle one): YES NO

Health Profile:

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐

If you came in today for a specific complaint, please fill out the next portion briefly describing it:

If he/she is experiencing pain, is it (check all that apply):

☐ Sharp
☐ Burning
☐ Dull
☐ Comes and Goes
☐ Travels
☐ Shooting
☐ Aching
☐ Burning
☐ Constant
☐ Worse with movement

Since the problem started is it:

☐ Same ☐ Better ☐ Getting Worse

What makes it worse? _____

What does it interfere with? _____

Who else have you seen for the issue? _____

- Has it helped? _____

List medications the child is currently taking:

_____

_____

_____

Past surgeries, traumas or accidents:

_____

_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Was IVF needed? Explain: _____

Third trimester presentation: ☐ Head down ☐ Breech ☐ Transverse ☐ Face/Brow

Were there any complications to the pregnancy? _____

Was Mom on any medications (prescription or over the counter)? _____

- If yes, please explain: _____

Did Mom or Dad ever smoke during pregnancy? Yes/No (circle one) Who? _____

How many ultrasounds were performed? _____

Birth and Delivery:

Where was the baby born? ☐ Home ☐ Hospital ☐ Birthing center

☐ Other: _____ ☐ Transfer?

Was the delivery: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum/ Suction Cap

How long was labor? _____ How long was the delivery? _____

Was oxytocin/Pitocin used? Yes/No (Circle one)

Was an epidural used? Yes/No (Circle one

Birth Weight _____ Length: _____

Congenital anomalies/Defects?_____

Check any box that applies **currently** *or* in the **past**:

- ☐ Seizures
- ☐ Ear/Sinus infection
- ☐ Asthma
- ☐ Allergies & congestion
- ☐ Failure to thrive
- ☐ Colic/Excessive crying
- ☐ Immune deficiency
- ☐ Headaches/migraines
- ☐ Vision/hearing issues
- ☐ Low energy & Fatigue
- ☐ Sensory/Spectrum
- ☐ ADD/ADHD
- ☐ Focus/Memory issues
- ☐ Anxiety/ Stress
- ☐ Speech issues
- ☐ Depression
- ☐ Reflux/GERD
- ☐ Chronic cough/colds
- ☐ Diabetes Mellitus type ____
- ☐ Bronchitis/Pneumonia
- ☐ Jaundice
- ☐ Eczema
- ☐ Food allergies
- ☐ Bedwetting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Lower Back pain
- ☐ Kidney issues
- ☐ Knock Knee
- ☐ Scoliosi

Childhood years(1years+):

Did the child have any childhood illnesses? Yes/No (Circle one)

- If yes, Explain: _____

Does the child play any youth sports? Yes/No (Circle one)

- If yes, which one(s)? _____

Has the child suffered from emotional traumas? Yes/No (Circle one)

Please give us any other health information you feel would be helpful:

_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to Gleason Family Chiropractic to examine and care for my child.

Guardian's Signature: _____

Relationship to child : _____ Date signed: _____