TriStar
Family Chiropractic
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CHILD'S HEALTH HISTORY FORM

Patient's Name:

_____

First Middle Last

Parent/guardian name:

_____

Chiropractic Wellness care is possible only when the physician completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Please write legibly and answer all questions thoroughly. Please mark anything you may have a question about.

Address: _____
City: _____ State: _____ Zip code: _____
Telephone numbers: home _____ work/cell _____

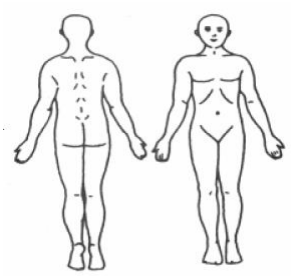
Preferred # for appointment reminders and other messages – no health information will be disclosed:
(_____) _____-_____ Email: _____

Is it ok to receive text messages or e-mail? Y/N

Birth date: _____ Age: _____ Gender: _____
Emergency contact: _____
Relationship: _____ Telephone number: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Dr. Gloria Arroyo-Grubbs, DC to release information necessary to secure payment.
Signature: _____ Date: _____

Is your child currently stating or acting as if they are in pain or discomfort? □Y □N
If so, can you complete the attached diagram and show areas of pain or discomfort:
***PLEASE MARK** the areas on the Diagram with the following **letters** to describe the symptoms: **R** = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing ,**T**= **T**ingling*
What relieves the symptoms? _____ What makes them feel worse? _____
Any restricted activities, eg walking, climbing stairs, sleeping due to pain or discomfort: □Y □N
_____



Is your child currently receiving health care? ✎Y ✎N If yes, please list current providers:
_____

If no, when and where did your child last receive medical care?_____

Child's general state of health is: __ Excellent __ Good __ Fair __ Poor
Date of last physical: _____
Date of last dental exam if applicable: _____
Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold,dust) That your child might have? If yes, please list and explain:

_____

_____

SELF & FAMILY HISTORY

What is/are the main goals for your child's visit to our clinic today?
_____
_____
_____

What are your child's most important health problems? List as many as you can in order of importance.
1) _____ This began _____
2) _____ This began _____
3) _____ This began _____
4) _____ This began _____
5) _____ This began _____
6) _____ This began _____

What hospitalizations, traumas/accidents or surgeries has your child had?
_____
_____

Please list any recent labwork with any abnormal results? _____

What diagnostic imaging studies has your child had? (Please circle all applicable)

✎ Electrocardiogram ✎ Electroencephalogram ✎ X-rays ✎ CT scan ✎ MRI
✎ Ultrasound ✎ Other

Medications and/or Supplements
Does your child take or use any of the following? (Please circle all applicable)
✎ Pain relievers (aspirin, ibuprofen) ✎ Antibiotics ✎ Laxatives
✎ Cortisone (cream or pills) ✎ Antacids

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements your child is taking with dosages and brand names if possible:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Family History

Please list any major illnesses or disease for your child's first degree relatives: Mother, Father, Brother, or Sister, along with age of diagnosis or death if appropriate.

_____
_____
_____

Prenatal History:

Mother's age at child's birth: _____ Prenatal care? ✎Y ✎N
Difficulty conceiving?_____ Infertility treatments used?_____
_____

During pregnancy, did the mother experience? (Please circle all applicable)
✎ Bleeding ✎ Drug/Alcohol Abuse ✎ Hypertension ✎ Medications
✎ Physical Trauma ✎ Thyroid Problems ✎ Gestational Diabetes
Specific food cravings/dislikes during pregnancy: _____
Did the Mother use any of the following during the pregnancy? (Please give details)
Tobacco _____
Alcohol _____
Recreational drugs _____
Prescription drugs _____
Over-the-counter medication_____
Supplements _____
Other _____

Birth History:

Pregnancy length: Full Premature _____wks Late _____wks
Length of labor: _____
Birth weight: _____ Length: _____

Was the birth: ✎Vaginal ✎C-section ✎Induced ✎Forceps
Any problems? _____
_____
Did the child experience any of the following symptoms after birth? (Please circle all applicable)
✎Jaundice ✎Rashes ✎Seizures ✎Other

Feeding/Diet History:

Breast Fed? _____ How long? _____
Formula Fed? _____ How long? _____ What type? _____
What foods were introduced before 6 months (please list approximate months as well):
6-12 months?
Did your child ever experience colic? _____ How severe? ✎mild ✎moderate ✎severe
Please list any food allergies or intolerances, along with the reaction they provoke.
What foods does your child crave/insist upon?
Does your child have any dietary restrictions(religious, vegetarian/vegan etc.)?
Describe Child's Typical Daily Diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Number of bottles given per day: ____ Number of ounces per bottle: _____

Child's Past Medical History: (Please circle all applicable-if not sure just give month/year)

✎ Chicken pox ✎ Measles ✎ Mumps ✎ Rubella ✎ Scarlet Fever
✎ Strep throat ✎ Pneumonia ✎ Colic ✎ Croup ✎ Bronchitis
✎ Tonsillitis ✎ Asthma ✎ Allergies ✎ Ear Infection ✎ Roseola
✎ Impetigo ✎ Mononucleosis ✎ Whooping Cough
Immunization History: number received / number suggested by CDC
✎ Diphtheria: /5 ✎ Pertussis: /5 ✎ Tetanus: /5 ✎ Polio: /4
✎ Hepatitis B: /3 ✎ Measles: /2 ✎ Mumps: /2 ✎ Rubella: /2
✎ Rotavirus: /3 ✎ Pneumococcal: /4 ✎ Influenza: /yearly ✎ Varicella: /2
✎ H. Flu: /4 ✎ Tetanus booster? _____ ✎ Hepatitis A: /2 ✎ Other?

Please indicate any adverse reactions to vaccines
_____
_____
How many times has your child been treated with antibiotics? _____
When and for what reason? _____
_____

Health and Development:
How was your child's health in the first year? ✎Poor ✎Fair ✎Good ✎Excellent ✎Unknown
If poor or fair circled, please describe: _____
_____

At what age did your child, first
Sit up _____ Crawl _____ Walk _____ Talk _____
Describe your child's sleep pattern:
How would you describe your child's temperament?
How would you describe your child's behavior and performance at school?

Environment:
Is your child in: school (grade_____), daycare/homecare, or other _____

***Thank you* for taking the time to fill out this questionnaire. I look forward to working with you!**