Horace Family Chiropractic, PC
534 North Main Street
Horace, ND 58047

(701) 532-3100
Fax: (701) 532-3101
www.horacefamilychiro.com

Pediatric Health History Form

At Horace Family Chiropractic our primary focus is on overall health. We know that many childhood and adult problems arise in pregnancy, or by events occurring during labor and delivery .Please be specific so that we can address your primary concern for visiting us today. The following questions will also give us a profile of the specific stresses that may impact this child's health in the future. All information is confidential.

General Patient Information

Child's Name (last, first) ____

Birth Date__________________ Age_______Sex_____male () female ()__

Parent or Guardian (last, first) & Relation to Patient ________________________________

Mailing address (street, city, zip): ____

Phone # (Primary & Secondary)____________________(Email)________________________________

Emergency Contact____Phone # ______________________

____

Did someone refer you to us? If so, please list their name so we can thank them______________________

If not, how did you hear about Horace Family Chiropractic? ____

Insurance Information

Does this patient have health insurance? () yes () no

Name of company ______________________________ Policy Number __________________

-Although most policies cover chiropractic, the frequency of care and amount reimbursed varies and is not guaranteed. Regardless of your health insurance coverage, Horace Family Chiropractic believes in recommending the care you need to get well and stay well. In signing the above, I understand and agree that my health/accident insurance policies are an arrangement between the insurance carrier and myself. All services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable to Horace Family Chiropractic. -

Signature of Guarantor______________________________________ Date ____________________

If auto accident, worker's compensation, or personal injury case please specify:

Contact Person____________________________________Phone # __________________________

Claim # ____

Name of Insured ____

Health Objectives

Chief Concern for Today's Visit ____

Other Concerns ____

Injury Date(if applicable)________________Symptom Onset Date(if applicable) ________________

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Prenatal History

Problems during pregnancy?____

Was there alcohol, tobacco, illicit, over-the-counter, or prescription drug use during pregnancy?

Yes / No / Unsure List ______________________________

Circle type of birth. Vaginal / Forceps / Vacuum / Breech / Cesarean - planned or emergency

Problems during labor/delivery? ____

Was there medicine or anesthesia used during labor or delivery?

Yes / No / Unsure List ______________________________

Did the provider use their hands to assist delivery? Yes / No / Unsure

If Yes, did he/she turn or pull the baby's head? Yes / No / Unsure

Was there visible injury to the baby after delivery?

Yes / No / Unsure List ______________________________

Weeks of Gestation at Birth__________ Birth Weight________ Birth Length _________

Feeding History

Was your child breast fed? Yes / No If yes, how long? ___________

If formula fed, list types used ____

When was your child introduced to solids?___________Cow's Milk? ____________

Does your child have food/liquid allergies or intolerances? Yes / No / Maybe

Developmental History

Has your child met all developmental landmarks on time? Response to sound/light, hold head up, sit up alone, cross crawl, stand alone, walk alone, first words…

Yes / No / Unsure List ____________________________

Are you concerned about the possibility of developmental delays? Check all that apply.

() doesn't respond to my voice
() doesn't track with eyes
() favors hold head to one side only
() difficulty crawling (all fours)
() skipped crawling stage all together
() seems clumsy with walking
() clumsy with large motor coordination
() falls often
() difficulty writing or buttoning clothes
() hard time learning to read
() difficulty sitting still
() poor concentration
() hard time interacting with peers
() difficulty controlling bladder (enuresis)

Lifestyle

What does your child's typical daily diet consist of?

Breakfast ____

Lunch____

Dinner ____

Snacks____

How could their diet be changed for the better?______________________________

Hours your child watches tv/spends on the computer/plays video games per day ____

Rate the following on a scale of 0-10 (0 = Poor, 10 = Excellent)

Sleep Patterns _________ Diet__________ Exercise _________ Emotional Health _________

Family History

Do your child's mother, father, siblings, aunts/uncles, or grandparents have any of the following?

Cancer ___________ Heart Disease ___________ Diabetes ___________ Depression __________

Autoimmune disease ______________ Arthritis _____________ Other____________________

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General Health History

Has your child ever been diagnosed with or experienced the following? Check all that apply.

() ADD/ADHD
() Asthma
() Allergies to Food
() Allergies to Environments
() Anxiety
() Autism/Autism Spectrum Disorder
() Behavioral Problems/Temper
() Bedwetting
() Bladder Control Problems
() Cancer
() Chemical Sensitivities
() Chronic Ear Infections
() Chronic Upper Respiratory Infections
() Colic
() Constipation
() Diabetes
() Digestion Problems
() Diarrhea
() Dizziness
() Dyslexia
() Epilepsy
() Fainting
() Gastric Reflux
() Head Injury
() Headaches
() Hearing Loss/Impairment
() Heart Disease
() High Blood Pressure
() Hypoglycemia (low blood sugar)
() Joint or Muscle Problems
() Meningitis
() Neck or Back Problems
() Nightmares
() Obsessive Compulsive Disorder (OCD)
() Seizures
() Serious Injuries/Falls
() Serious Illness
() Sinus Infections
() Surgeries
() Thumb Sucking
() Tourette’s
() Vision Problems
() Other: ______________________________

Medications

Prescription :____Reason:__________
Over-the-counter: ____
Supplements: ____
Was your child vaccinated? Yes / No / Unsure / Yes, but not the full schedule
Did they experience any immediate or delayed adverse reactions? Yes / No / Unsure Has your child ever been on antibiotics? Yes / No / Unsure How many courses? __________

Injuries/Accidents

Studies by the International Safety Council show that 50% of children will fall on their heads during their first year of life. Another 250.000 children are injured on playgrounds annually.

Type ____ Date __________
____ __________
____ __________

Surgeries/Hospitalizations

Reason ____ Date __________
____ __________
____ __________

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Consent for Treatment of Minor

I,___________________________, being the parent or legal guardian of_________________________, understand the nature of chiropractic treatment and grant authorization for Horace Family Chiropractic, PC for care of my child.

____ _______________________

Signature of Parent/Guardian **Date**