Confidential Youth Patient Health Record

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Patient Information

Child's Name ____

Mother's Name ____ Mother's Cell _______________________

Father's Name ____ Father's Cell _______________________

Marital Status: M S W D C

Who is the primary contact? Mother Father Other: ______________________________________

E-mail address ____

Address ____ City _________________________________

Postal Code ____

Child's Date of Birth (Y) _________ / (M) ________ / (D) ________ Sex: M F

How were you referred to our office today? ____

Reason for consulting our office today ____

____

Why Providing This Information Is Important

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. The human body is designed to be healthy. On a daily basis we experience physical, chemical and emotional stressors that can accumulate and result in serious loss of good health. The effects are often gradual and not felt until they become more serious. Our goal is to address the issues that brought your child to our office today, and to offer you the opportunity to improve their overall health.

Your Child's Birth

	Yes	No
Did you carry your pregnancy to full term?		
If no, how many weeks gestation?	__________	

Describe any complications that occurred:

____

____

Did you breastfeed? ☐ Yes ☐ No For how long? ____

Did you use formula? ☐ Yes ☐ No Which brand, and for how long? ______________________________

Did you take any medication during your pregnancy? ☐ Yes ☐ No

Which medications? ____

Please tell us about the delivery and birth of your child:

Did you deliver at the hospital or at home? □ Hospital □ Home

Did you use an obstetrician or midwife? □ Obstetrician □ Midwife

Did you have a C-Section? □ Yes □ No

Were foreceps used? □ Yes □ No

Was vacuum extraction used? □ Yes □ No

Were you induced? □ Yes □ No

Did you have an epidural? □ Yes □ No

Did your baby have initial respiratory delay? □ Yes □ No

Did your baby have purple markings on their face? □ Yes □ No

Did your baby have a mis-shaped head or skull? □ Yes □ No

What was your child's birth weight? ______________

Was it a difficult birth? If so, please share these details.: ____

____

About Your Child

As a Baby/Toddler (4 years of age and younger), did any of the following occur?

	Yes	No		Yes	No
Fall from a change table?	□	□	Tonsillitis?	□	□
Tumble down the stairs?	□	□	Sleeping issues?	□	□
Fall out of a crib or playpen?	□	□	Frequent fevers?	□	□
Fall from playground equipment?	□	□	Did not gain weight?	□	□
Jumped in a "Jolly Jumper"?	□	□	Frequent crying spells?		□
Frequent ear infections?	□	□	Frequent bouts of diarrhea?		□
Reaction to vaccinations?	□	□	Colic?		
Frequent bouts of constipation?	□	□	Other:		

As a young child (5-12 years of age), did any of the following occur?

	Yes	No		Yes	No
Fall from a tree?	□	□	Bed wetting?	□	□
Fall off a bicycle?	□		Hyperactivity?	□	□
Fall off playground equipment?	□	□	ASD diagnosis?	□	□
Sports accident?	□	□	Asthma?	□	□
Car accident?	□	□	Allergies?	□	□
Stomach pains?	□		Leg pains?	□	□
Scoliosis?	□		Other:		

Please provide additional information about the above: ____

____

	Yes	No
Has your child received any vaccinations?	◻	◻
If yes, did they have any reactions? ______________________________		
Has your child had any illnesses?	◻	◻
Details: ______________________________		
Has your child had any concussions?	◻	◻
If yes, when and how many: ______________________________		
Does your child play contact sports?	◻	◻
Details: ______________________________		
Has your child suffered any other physical or emotional traumas?	◻	◻
Details: ______________________________		
Has your child previously been under regular chiropractic care?	◻	◻

If so, please explain the reason for starting and discontinuing care: ___________________________________

____

List any medications your child is currently taking ____

Approximately how many antibiotics have been prescribed for your child, and for what conditions?

____

____

If your child has no specific symptoms or complaints, and they are here for wellness care, please check here:

Please describe the primary complaint your child has, and how long it has lasted.

____

____

When it is at its worst, how does it make your child feel?

____

What have you done about it that has NOT worked?

____

What makes it worse? ____

What relieves it? ____

What effect does this problem have on your child's body functions and daily activities? _________________

____

Please check off **ALL** of the symptoms your child has ever had, even if you don't feel they are related to your child's current issue.

Cervical Spine

- ◻ Headaches
- ◻ Migraines
- ◻ Fatigue
- ◻ Difficulty Sleeping
- ◻ Anxiety
- ◻ Depression
- ◻ Neck Pain
- ◻ Dizziness
- ◻ Vertigo
- ◻ Sinus Infections
- ◻ Lack of Concentration
- ◻ Arm pain/numbness ◻ Left ◻ Right
- ◻ Hand pain/numbness ◻ Left ◻ Right
- ◻ Persistent Cough
- ◻ Frequent Colds / Flu
- ◻ Buzzing / Ringing in Ears
- ◻ Earaches / Ear infections
- ◻ Hearing Loss
- ◻ Frequent Nausea
- ◻ Seasonal Allergies

General

- ◻ Allergies
- ◻ Hyperactivity / ADHD
- ◻ Morning Stiffness / Pain
- ◻ Stress
- ◻ Cancer, Type: ______________________________

Thoracic Spine

- ◻ Mid Back Pain
- ◻ Pain Between the Shoulders
- ◻ Chest Pain
- ◻ Heart Issues / Palpitations / Arrhythmia
- ◻ Heartburn / Acid reflux / GERD
- ◻ Shortness of Breath
- ◻ Asthma
- ◻ Bronchitis / Pneumonia
- ◻ Shoulder Pain ◻ Left ◻ Right

Lumbar Spine

- ◻ Low Back Pain
- ◻ Scoliosis
- ◻ Irritable Bowel Syndrome
- ◻ Constipation
- ◻ Diarrhea
- ◻ Urinary Infections
- ◻ Diabetes
- ◻ Leg Pain/Numbness ◻ Left ◻ Right
- ◻ Hip Pain ◻ Left ◻ Right
- ◻ Knee Pain ◻ Left ◻ Right
- ◻ Ankle Pain / Swelling ◻ Left ◻ Right
- ◻ Foot Pain ◻ Left ◻ Right
- ◻ Shin Pains
- ◻ Growing Pains

Is there anything else you feel we should know?

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Names of other Health Care Professionals you have seen for this problem:

Chiropractor ____

Family Doctor ____

Other ____

Parent/Guardian's Signature: ________________________________ Date: ________________