INFINITE LIFE
CHIROPRACTIC

PEDIATRIC HEALTH HISTORY

Child's Name: _____ Birth Date: _____
Age: _____ Gender: _____ Height: _____ Weight: _____
Parent's/Guardians' Name: _____
Home Address: _____ City:_____ State:_____
Zip: _____ Parent's Email:_____
Parent's Cell Phone:_____ May we leave a message? Yes No
Parent's Work Phone:_____ May we leave a message? Yes No
Siblings and ages: _____
How did you hear about us? _____
Has your child ever been under Chiropractic Care? • Yes • No

Emergency Contact

Name: _____Relationship to child: _____
Phone Number: _____ Alternative phone number: _____

Family Doctor

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your family doctor regarding your child's care if necessary? Yes No

Why have you decided to have your child evaluated by a Chiropractor?

- ❑ He/She is continuing care from another chiropractor.
- ❑ I recently had my spine checked and understand the value in getting my child checked.
- ❑ I have concerns about his/her health and I'm looking for answers.
- ❑ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ❑ I want to improve my child's immune function.

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)
Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
•	•	Asthma	•	•	Frequent Diarrhea	•	•	Failure to Thrive
•	•	Respiratory Infections	•	•	Constipation	•	•	Slow or Absent Reflexes
•	•	Sinus Problems	•	•	Flatulence	•	•	Asymmetrical Crawling/Gait
•	•	Ear Infections	•	•	Headaches/Migraines	•	•	Weight Challenges
•	•	Tonsillitis	•	•	Neck Pain	•	•	Bed Wetting
•	•	Strep Throat	•	•	Back Pain	•	•	Sleep Problems
•	•	Frequent sickness	•	•	Growing Pains	•	•	Concentration Problems
•	•	Recurrent Fevers	•	•	Torticollis/Head Tilt	•	•	Tie Toe Walking
•	•	Eczema	•	•	Trouble feeding on one side	•	•	Sensory Processing Issues
•	•	Rashes	•	•	Scoliosis	•	•	Seizures
•	•	Allergies	•	•	Red, Swollen, Painful Joints	•	•	Tremors/ Ticks
•	•	Food Sensitivities	•	•	Colic	•	•	ADD/ADHD
•	•	Digestive Problems	•	•	Frequent Crying	•	•	Autism

Do you have a specific concern that brings you in?

- ❑ No, I would like my child's nervous system assessed to achieve optimal health & functioning.
- ❑ Yes:_____

_____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ When did it start? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

Have you seen other health professionals regarding this complaint? • Yes • No

If Yes, Whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? • No • Yes: _____

Has your child ever experienced this complaint before? • No • Yes: _____

Has your child had x-rays in relation to the current complaint? • No • Yes: _____

Birth Experience

Location of Birth: • Home • Hospital • Birthing Center Other: _____

Medications during labor/delivery (including IV antibiotics): • No • Yes: _____

Was Pitocin used to induce / speed up labor? • No • Yes

Was your child at any time during pregnancy in a constrained position? • No • Yes • Unsure

If yes, please describe: • Breech • Transverse • Face / Brow presentation
Was your delivery vaginal or C-section? • Vaginal • C-Section: Planned or emergency?
If it was vaginal, was the baby presented: • Head • Face • Breech
Were any of the following interventions used? • Forceps • Vacuum Extraction • Other: _____
Were there any complications during delivery? • No • Yes
If yes, please specify: _____
Was the baby born with any purple markings / bruising on their face or head? • No • Yes: _____
Any concerns about misshapen head at birth? • No •Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____
Was the baby ever admitted to the NICU? • No • Yes
If yes, for how long and why? _____
Were there any medications given to the child at birth? • No • Yes • Unsure
If yes, what medication and why? _____
Was your child exclusively breastfed? • No • Yes: How many months: _____
Was your child breastfed + formula fed? • No • Yes: How many months: _____
Did your child show any sensitivities to formula (reflux, eczema, arching back)? • No • Yes
Has your child been vaccinated? • No • Yes
If yes, • Full • Partial • Delayed • Other: _____
Did your child have any reactions to vaccines? • No • Yes: _____

Physical Traumas

Has your child ever fallen from any high places? • No • Yes
Has your child ever been involved in a motor vehicle accident? • No • Yes
Has your child broken any bones? • No • Yes
Has your child had any previous hospitalizations? • No • Yes
Has your child had any previous surgeries? • No • Yes
Does your child use a tablet, computer, or video game? • Never • Rarely • Daily • Several hours/day
Does your child watch TV? • Never • Rarely • Daily • Several hours/day
Does your child exercise? • No • Daily • Weekly
Does your child play contact sports? • No • Daily • Weekly

Goals & Consent

Do you feel your child is developmentally appropriate for their age?
Intellectually: • Yes • No: _____
Emotionally: • Yes • No: _____
Physically: • Yes • No: _____

What is your primary goal for your child in this office?

_____

_____

Our goals are to provide a detailed assessment of your child's current status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow.

Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!