Pediatric Health Profile (0-7yrs)

Date: ______________________________

Patient's Full Name:____

Patient's Date of Birth: __________________________ Sex: M F

Day/Month/Year (circle one)

Parent's Names:____

Full Address:

____

Street # Street Name Unit # City Province Postal code

Telephone (Parents):

Mother: ____

Primary: Please circle (home) (work) (cell) Secondary: Please circle (home) (work) (cell)

Father: ____

Primary: Please circle (home) (work) (cell) Secondary: Please circle (home) (work) (cell)

____

Email Address (Parents)

How did you hear about our clinic? ____

FOR OFFICE USE: -

Date	Presenting/Major Complaints
A	
B	

Health Profile:

Main concern(s) that brings your child to our office:

____

____

When did this concern begin?

____

What do you believe caused this condition?

____

Child presently taking any medications? Yes __ No __

Please list: ____

Any behavioural concerns?

____

Any developmental delays?

____

Any learning challenges?

____

Patient's Past Health History:

Birth History

Length of pregnancy: ☐ Full Term ☐ Early (wks) ______ ☐ Late (wks) ______

Please list any challenges during pregnancy (blood pressure, baby position, sensitivities, etc): None (circle) or list: ____

Location of birth: ☐ Home ☐ Hospital ☐ Birth centre

Type of birth/delivery: ☐ Normal vaginal ☐ Breech ☐ Caesarean

Delivery procedures: ☐ Epidural ☐ Forceps ☐ Vacuum

Length of labour: ____________ Name of MD/OB/Midwife: ______________________

Birth weight: ___________ Birth length: ____________ APGAR Score: _______________

Presence at birth of: Jaundice *(yellow skin colour)* Cyanosis *(blue colour)* *(circle one)*

Congenital anomalies/defects: ____

Infancy History

☐ Breast fed Latching well: ☐ Yes ☐ No Breast preference: ☐ Yes (☐L ☐R) ☐ No

☐ Bottle ☐ Formula – type and age introduced: __________________________

# of hours of sleep each night __________ # of hours of sleep in a row ___________

Quality sleep: ☐ Good ☐ Fair ☐ Poor

Any delayed developmental milestones: ____

General Health History:

Falls or injuries: ____

____

Surgeries/Procedures/Diagnostic tests: ______________________________

____

Treatment for any health condition in the past year: □ Yes □ No If yes, please explain: ____

____

Previous chiropractic care and date of last visit: ______________________

Vaccination history: □ all current

____

Reactions to vaccination:

□ Fever □ Crying □ Vomiting □ Irregular sleep □ Skin reaction

____

Check any childhood diseases your child has had:

□ Measles □ Mumps □ Chicken pox □ Influenza □ RSV □ Croup □ Rheumatic fever □ Pneumonia □ Juvenile Diabetes

□ Other: ____

Please circle any of the following concerns that are a problem; and underline any that were a problem in the past.

			MUSCLE & JOINT:
Colic	Asthma	Allergies	
Extreme fussiness	Constipation	Diarrhea	Sore muscles
Screaming/crying	Vomiting	Stomach aches	Sore joints
Tilting head **R L**	Frequent colds	Food sensitivities:	Growing pains
Nursing preference	Earaches/infections	______________	Stiffness
R L	Bedwetting	______________	Neck problems
Difficulty nursing	Sore joints	Skin conditions:	Back problems
Slow weight gain	Sore muscles	______________	Spinal curvature
Gain of weight	Growing pains	Eczema	Walking problems
Poor appetite	Hyperactivity	Headaches	Feet turn in/out
Fussy eater	Behavioural issues	Fatigue	Hip joint issues

Family History:

Circle any that apply to your parents, grandparents and or siblings and explain.

Diabetes ______________________ *High blood pressure* ______________________

Stroke ______________________ *Heart disease* ______________________

Cancer ______________________ *Lung disease* ______________________

Seizures ______________________ *Tremors* ______________________

Neurological ______________________ *Arthritis* ______________________

Scoliosis ______________________ *ADD/ADHD*______________________

Other ____

Your Specific Needs and Goals:

What are your objectives in consulting our office?

____

Is there anything else that may help us to understand your child, your child's history, or your child's needs, which have not been discussed on this health profile? ____

____

Patient Name (print) ______________________________ **Date**____________

Parent/Guardian signature ____

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