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 _____

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
() falls often
() difficulty writing or buttoning clothes
() hard time learning to read
() difficulty sitting still
() poor concentration
() hard time interacting with peers

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**