Phone (509) 965-9820
Fax (509) 965-9822
www.Active-Life-Chiropractic.com

Pediatric Registration and Health History

Name: ____ **Today's Date:** __________
First Middle Last

Address: ____
Street Apt# City State Zip

Date of Birth: _____________ **Gender:** _____ **Contact Email:** ____________________

Mothers Name: ____ **Phone:** (____) __________

Fathers Name: ____ **Phone:** (____) ___________

• •

Present Complaint

What symptoms are you noticing or is your child experiencing? ____________________________
When did this begin? ____
Was there an accident or injury involved? __Y __N Describe _______________________________
Has there been past treatment for this complaint? __Y __N If Yes, please describe ________________
Current medications/vitamins/probiotics etc. ____

Prenatal History

Complications during pregnancy? __Y __N If Yes, please explain ___________________________
Any ailments during pregnancy? __ Y __ N Did you exercise and eat well during pregnancy __Y __N
Was your baby breech position? __ Y __ N
Medications or supplements taken during pregnancy: ____________________________________
Cigarettes or alcohol during pregnancy? __Y __N Who was your provider ____________________

Birth

Birth weight _________ Birth length _________ Current Weight/% _________ Current length/% _________
APGAR score _____________ At birth: Jaundice (yellow) __Y __N Cyanosis (blue) __Y __N
Difficulties with labor _______________ Hours of labor ____ Time spent pushing_____ Gestational age at birth ____
Complications during delivery? __Y __N If Yes, please explain _____________________________
Birth intervention? __Forceps __Vacuum __C-Section __Epidural __Other __ None
Genetic disorders or disabilities? ____
Has your child received vaccinations? __Y __N If Yes, Which vaccines and what schedule you are following ________
How many times has your child been prescribed antibiotics in the last six months? ____________________
How many times antibiotic prescriptions in their lifetime? _____________________________________

Sleep

Number of hours sleeping per night _________ Quality of sleep? __Good __ Fair __ Poor

Naps/day and length ____

Feeding

Breast ____ Formula ____ Type of formula? ______________________ Type of Bottles? ______________________
Pacifier use? __Y __N Type, ____________________ Any issues noticed? ____________________________________
How would you rate your child's appetite? __ Above average __ Average __ Below average
Avg # of feeds: _________ Solid food introduction? __Y __N Age? _____________
How would you rate your child's diet? __ Well-balanced __ Average __ High sugar/processed foods
Any artificial sweetener use? __Y __N
Has your child been checked for a lip tie or tongue tie? ____

Family History/Genetic Diseases? ____

Any change in bowel or bladder habits? __Y __N If Yes, please explain ____________________________________

Any change in child's disposition, attitude or personality? __Y __N If Yes, please explain ____________________

Is the child in a car seat? __Y __N Forward or Rear facing? Hours in car seat/day? ___________________

Do you wear your child? __Y __N Type of carrier used/hours used ____________________________________

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic. Check each developmental milestone your child has reached:

__ Respond to Sound
__ Cross Crawl
__ Respond to Visual Stimuli
__ Stand Alone
__ Hold Head Up Alone
__ Walk Alone
__ Sit up Alone

It is common for children to fall head first from a high place during the first year of life, has this been the case with your child? __ Y __N If Yes, please explain ____

Does your child wear a backpack? __ Y __ N

Has your child been involved in any high impact or contact type sports? __Y __N

Has your child been involved in a car accident? __Y __N If Yes, please explain ____________________________

Other traumas your child may have sustained? __Y __N If Yes, please explain ____________________________

Prior surgeries/Replacements? __Y __N If Yes, please explain ______________________________________

Review of Systems Please check each of the following your child has had

__Feeding/Latching issues
__Constipation
__Bleeding disorders
__Acid Reflux
__ Allergies
__Ear Infections
__Growing Pains
__Headaches
__Digestive Problems
__Asthma
__Autism
__Postural Imbalances
__Scoliosis
__Seizures
__ADD/ADHD
__Hip Dysplasia
__Torticollis
__Learning disorders
__Colic
__Bedwetting
__Heart trouble
__ Walking issues
__Diabetes
__Anemia
__Hernia

Patient Name ____ DOB ____________

Parent Signature____ Date ____________