ACTIVE LIFE CHIROPRACTIC
a Sports Injury & Family Practice

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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 _____