EXODUS HEALTH CENTER
Dr. David Jockers/ Dr. Adriana Bedford Blaise

INDIVIDUALIZED PEDIATRIC HISTORY FORM

IT'S ALL ABOUT THE UNIQUENESS OF YOUR CHILD

PATIENT DEMOGRAPHICS
HR#:_________________

Childs Name____ Today's Date ____/____/___

Date of Birth ____/____/_____ Birth Height: ______ Birth Weight: ______ Current Height: _____

Current Weight: ____ Age: ____ Address ____

City _________________ State ______ Zip _______________ Phone (Home) _________________

Mothers Name: ____________________Mother's Mobile ______________________DOB___/___/___

Fathers name: ____________________Father's Mobile______________________DOB ___/___/___

Pediatrician/Family MD _______________________________City & State ______________________

Last Visit: ___/___/___ Reason for visit:____

Who is responsible for this bill? ____

☐ *Other (please explain):*

Purpose of this visit: ____Wellness Check ____Injury or Accident ____Other Health Challenge

1. *If your child is experiencing* ***Pain/Discomfort/health challenges please identify what, where and for how long (when did you first notice this sign of body dysfunction?*** Date ___/___/___)

____

____

____

Has your Child **Ever had** this problem **before**? __________NO ____________YES

If yes when? ____

PRESENT HEALTH CHALLENGES

What do you feel is the cause of your child's problem?

____

____

____

How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Why do you think so?

____

____

____

What are the most significant measures you have taken to date to improve your child's present health challenge?
Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

____

____

____

____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

____

____

____

____

2. Has your child ever sustained an injury playing organized sports? _______ If yes; please explain

   ____

   ____

   ____

   ____

3. Has your child ever sustained an injury in an auto accident? _______ if yes, please explain

   ____

   ____

   ____

   ____

4. ***HAS YOUR CHILD EVER SUFFERED FROM:*** *CHECK ALL THAT APPLY*

☐ Headaches ☐ Orthopedic Problems ☐ Digestive Disorders ☐Behavioral Problems
☐ Dizziness ☐ Neck Problems ☐ Poor Appetite ☐ ADD/ADH
☐ Fainting ☐ Arm Problems ☐ Stomach Aches ☐ Ruptures/Hernia
☐ Seizures/Convulsions ☐ Leg Problems ☐ Reflux ☐ Muscle Pain
☐ Heart Trouble ☐ Joint Problems ☐ Constipation ☐ Growing Pains
☐ Chronic Earaches ☐ Backaches ☐ Diarrhea ☐ Allergies
☐ Sinus Trouble ☐ Poor Posture ☐ Hypertension ☐ Asthma
☐ Scoliosis ☐ Anemia ☐ Colds/Flu ☐ Walking Trouble
☐ Bed Wetting ☐ Colic ☐ Broken Bones ☐ Sleeping Problems
☐ Fall in baby walker ☐ Fall from bed or couch ☐ Fall from crib ☐ Fall off swing
☐ Fall off bicycle ☐ Fall from high chair ☐ Fall off slide ☐ Fall down stairs
☐ Fall from changing table ☐ Fall off monkey bars ☐ Fall off skateboard/skates ☐ Other: ________

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Number of doses of antibiotics has your child taken: __________in the past 6 months _____________in his/her lifetime

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

____

____

____

Vaccination History:____

PRENATAL HISTORY:

Type of birth attendant: OBGYN CNM LAY MIDWIFE

Name of Attendant:____

Location of birth: ____________Home ______________Birthing Center ______________Hospital______________

Complications During Pregnancy: ________NO _________YES List:_______________________________________

Ultra Sounds During Pregnancy: _________ NO _________YES Number:_____________________________

Medications During Pregnancy/ Delivery:___________ NO ______________ YES LIST:_______________
____

Birth Intervention: _____Forceps ______Vacuum ___________Caesarian: Planned or Emergency

Complications during Delivery: _____________NO _______________ YES LIST:_______________________
____

Genetic Disorders or disabilities: ___________NO _______________YES LIST:______________________

Cigarette or Alcohol Use during Pregnancy:______________NO _________YES

Birth Weight____________ Birth Length________________ APGAR score_____________________________

FEEDING HISTORY:

Breast fed:________ NO _________YES How long? __________

Formula Fed:__________NO __________YES How long?___________

Type of formula:_______________

Introduced to solids at_____________ Months, Type:____________________________

Cow's Milk at ___________________Months

DEVELOPMENTAL HISTORY:

Number of hours of sleep/ night:________________

Quality of sleep: GOOD FAIR POOR

At what age was your child able to

____________ Respond to sound

____________ Respond to Visual Stimuli

____________ Hold Head up

____________ Sit Up

____________ Cross Crawl

____________ Stand Alone

____________ Walk alone

CHILDHOOD DISEASES:

Chicken Pox: NO/YES AGE:____________ **Mumps:** NO/YES AGE_____________

Rubella: NO/YES AGE:____________ **Whopping Cough:** NO/YES AGE:_____________

Rubeola: NO/YES AGE:____________ **Other:**__________ NO/YES AGE:____________

According to the National Safety Council, Approximately 50% of all children Fall head first from a hight place during their first year of life (ie: a Bed , changing table, down stairs, etc) Was this the case with your Child? _____No _____Yes

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemical? ____ Yes ____No

If yes, for what reason and for how long?

____

____

____

Has your child ever been hospitalized? ____ Yes ____No

If yes, why and when? (Please list in chronological order)

____

____

____

____

I understand that I am directly and fully responsible to EXODUS HEALTH CENTER for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

______________________________ ____________________

Parent or Legal Guardian's Signature Date

Doctor Signature ______________________________ Date________________