CHILD HEALTH HISTORY

Name of Patient _____ Date _____

Gender _____ Date of Birth ____/____/____ Age _____

Address _____ Phone Number _____

Parent(s) Name _____

Education Level Attained _____ Age _____

Parent(s) Name _____

Education Level Attained _____ Age _____

Legal Guardian _____

Person completing form _____

Email _____

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems. **Please check any box that applies and/or add notes**

Has anyone in the family had:	*Siblings*	*Parents*	*Extended Family*
Motor problems	☐	☐	☐
Reading problems	☐	☐	☐
Speech/language problems	☐	☐	☐
School/learning problems	☐	☐	☐
Alcohol/drug problems	☐	☐	☐
Anxiety, depression, other psychological disorders	☐	☐	☐
Seizures/epilepsy	☐	☐	☐
Attention problems	☐	☐	☐

Please list all family members (in or out of the house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐

BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list. Example: gestational diabetes, pre-eclampsia, high blood pressure, etc?

_____

Did you receive any vaccinations while pregnant? ☐ Yes ☐ No

Was any dental work done while pregnant? ☐ Yes ☐ No

If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of a spouse's job, separation, etc?

_____

Please check what best describes your labor and birth of your child?

- ☐ Normal (no interventions)
- ☐ Mother was sick
- ☐ Complications during birth
- ☐ Problems with the umbilical cord
- ☐ Rh Factor problems
- ☐ Long/difficult labor
- ☐ Epidural given
- ☐ Facial/breech/brow presentation
- ☐ Cesarean section
- ☐ Forceps or suction used
- ☐ Induced

Did your child have any of the following problems at birth?

- ☐ Difficulty breathing
- ☐ Low birth weight
- ☐ Fever or seizures
- ☐ Bruised anywhere
- ☐ Health problems
- ☐ Problems with bones/joints
- ☐ Required blood transfusions
- ☐ Nerve problems
- ☐ Infection
- ☐ Jaundice
- ☐ Intensive care

Does this/did this child have any birth defects? ☐ Yes ☐ No

If yes, what? _____

Describe what your child's temperament was like as an infant.

- ☐ Difficult
- ☐ Irritable
- ☐ Sociable
- ☐ Calm
- ☐ Active
- ☐ Cranky
- ☐ Sleepy
- ☐ Easily scared
- ☐ Happy
- ☐ Hyper sensitive
- ☐ Frequent crying
- ☐ Alert

During the first twelve months, was this child:

Difficult to get to sleep ☐ Yes ☐ No

Difficult to put on a schedule ☐ Yes ☐ No

Easy to comfort ☐ Yes ☐ No

Overactive/in constant motion ☐ Yes ☐ No

Was the child breastfed? ☐ Yes ☐ No

Irritable ☐ Yes ☐ No

Alert ☐ Yes ☐ No

Affectionate ☐ Yes ☐ No

Sociable ☐ Yes ☐ No

For how long? _____

When was solid food introduced? _____

Was there any evidence of food intolerance? ☐ Yes ☐ No

If so, to what? _____

DEVELOPMENTAL HISTORY

How old was the child when (s)he:	Average Age	Approximate Age	If not sure, please estimate		
Sat	4-7 mos		☐ Early	☐ Average	☐ Late
Crawled	9-12 mos		☐ Early	☐ Average	☐ Late
Walked	12-17 mos		☐ Early	☐ Average	☐ Late
Toilet Trained	18-36 mos		☐ Early	☐ Average	☐ Late
Said first words	12-17 mos		☐ Early	☐ Average	☐ Late
Began using sentences	36-60 mos		☐ Early	☐ Average	☐ Late

SPEECH AND LANGUAGE

Has his/her hearing ever been tested? ☐ Yes ☐ No

Does this child have a history of frequent ear infections? ☐ Yes ☐ No

Has (s)he ever had tubes placed in her/his ears? ☐ Yes ☐ No

Last hearing/audiology evaluation: PLACE_____ DATE: _____

Does this child have:

Any speech problems/difficulty speaking? ☐ Yes ☐ No

Have any trouble understanding what is being said to him/her? ☐ Yes ☐ No

Has (s)he ever had a Speech and Language Evaluation? ☐ Yes ☐ No

If yes, where?_____ When?_____

RESULTS _____

Has (s)he ever had Speech/Language Therapy? ☐ Yes ☐ No

Is (s)he currently receiving Speech/Language Therapy? ☐ Yes ☐ No

If yes, where?_____

Frequency: _____

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? ☐ Yes ☐ No

Has (s)he ever had Occupational Therapy (OT) evaluation? ☐ Yes ☐ No

Is (s)he currently receiving OT services? ☐ Yes ☐ No

If yes, where?_____ Frequency: _____

Does (s)he have any gross motor problems (walking, running)? ☐ Yes ☐ No

Has (s)he ever had a Physical Therapy (PT) evaluation? ☐ Yes ☐ No

Is (s)he currently receiving PT services? ☐ Yes ☐ No

If yes, where?_____ Frequency: _____

Does this child use any adaptive devices (braces)? ☐ Yes ☐ No

If yes, please describe:

VISION

Has this child ever been to an eye doctor? ☐ Yes ☐ No

Most recent date: _____

Does this child wear glasses? ☐ Yes ☐ No

If yes, why? _____

Has this child ever been assessed for / diagnosed with:

☐ Binocular Vision ☐ Convergence Insufficiency

☐ Other Convergence Issues ☐ Fixation Issues

IMPORTANT: if a child wears glasses, please bring them to the appointment

MEDICAL HISTORY

Is the child regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath

☐ Naturopath ☐ Dentist ☐ Other

Has the child had the following childhood or other diseases?

☐ Bronchitis ☐ Allergies ☐ Abdominal Pains ☐ Pertussis ☐ Scarlet Fever

☐ Bed Wetting ☐ Asthma ☐ Croup ☐ Measles ☐ Meningitis

☐ Seizures ☐ Chronic Colds ☐ Colic ☐ Mumps ☐ Rubella

☐ Chicken Pox ☐ Ear Infections

Does this child have/had braces on his/her teeth? ☐ Yes ☐ No

Does this child have any amalgam fillings? How many? ☐ Yes ☐ No

How many continuous hours is the child sleeping? _____

Is she/he well rested in the morning? ☐ Yes ☐ No

Does the child suffer from sleeping difficulties? ☐ Yes ☐ No

Does the child have problems with food/eating? ☐ Yes ☐ No

Is the child a fussy eater? ☐ Yes ☐ No

Does the child have issues with hygiene/cleanliness? ☐ Yes ☐ No

Does the child complain of any ongoing physical pains? ☐ Yes ☐ No

(headaches, tummy aches, muscle/joint aches, or growing pains)

Does the child suffer from dry skin, dandruff, hard skin on elbows, ☐ Yes ☐ No

bumps on the outside of the arms, cracked heels, excessive thirst/urination?

Has this child received vaccines? ☐ Yes ☐ No

If yes, please list:

Were there any of the following adverse reactions noticed? ☐ Yes ☐ No

☐ Inconsolable crying ☐ High fever ☐ Sleep disruptions afterward
☐ Lethargy ☐ Irritability ☐ Developed allergies

How many courses of antibiotics has this child received?

Has this child taken any other prescription medication in the past? ☐ Yes ☐ No

If yes, what were they?

Is the child exposed to a toxic environment (including passive smoking)? ☐ Yes ☐ No

Has the child had any serious falls, physical traumas, or physical injuries? ☐ Yes ☐ No

Please list:

SCHOOL HISTORY

Does the child like/enjoy school? ☐ Yes ☐ No

If not, why not?

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

English	S ☐ W ☐	Math	S ☐ W ☐	Music	S ☐ W ☐
History	S ☐ W ☐	Science	S ☐ W ☐	Creative writing	S ☐ W ☐
Gym/Sports	S ☐ W ☐	Other languages	S ☐ W ☐	Other:	S ☐ W ☐
Art	S ☐ W ☐				

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

Vocabulary and expression	S ☐ W ☐	Reading quickly	S ☐ W ☐
Creative writing	S ☐ W ☐	Memorizing	S ☐ W ☐
Getting assignments done on time	S ☐ W ☐	Spelling	S ☐ W ☐
Understanding concepts	S ☐ W ☐	Planning	S ☐ W ☐
Reading comprehension	S ☐ W ☐	Concentration	S ☐ W ☐
"Good" behavior	S ☐ W ☐	Handwriting	S ☐ W ☐
Test preparation	S ☐ W ☐	Organization	S ☐ W ☐

Is getting homework done a struggle? ☐ Yes ☐ No

BEHAVIOR/MENTAL HEALTH

Describe any sports or activities the child is involved in:

Indicate how many hours a week of "screen time" the child uses:

Computer _____ Smart Device (phone, iPad, etc.) _____

Computer games (DS, etc.) _____ Television _____

Describe the child's family relationships; with parents and siblings: _____

Does your child have many friends? ☐ Yes ☐ No

Does the child appear to excel at or struggle to build relationships with their peers?

☐ Excel ☐ Struggle ☐ Neither

If they struggle, why do you think that is?

What problems does the child have with peers, if any?

☐ None ☐ Bragging to peers ☐ Being teased

☐ Being physically attacked ☐ Rejected by peers ☐ Overly physically affectionate

☐ Being bullied ☐ Jealous of peers

Does this child have self-esteem issues? ☐ Yes ☐ No

Which of the following has the child experienced in the last 12 months?

☐ Serious illness/injury in immediate family ☐ Change of school ☐ Mother pregnant

☐ Parents separation/divorce ☐ Move to a new home ☐ Parent losing a job

☐ Birth of a sibling ☐ Death of immediate family member

☐ None ☐ Other: _____

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age?

(Please check any that apply)

☐ Often touchy/easily annoyed ☐ Often bullies/threatens ☐ Often irritable

☐ Often defies adult rules ☐ Initiates physical fights ☐ Changes in appetite

☐ Often angry/resentful ☐ Ever been arrested ☐ Diminished interest

☐ Often argues with adults ☐ Physically cruel to others ☐ Sleep problems

☐ Often loses temper ☐ Physically cruel to animals ☐ Restlessness or slowed down

☐ Blames others for mistakes ☐ Motor or vocal tics ☐ Fatigues, low energy

☐ Deliberately annoys ☐ Destroys property ☐ Feels worthless

☐ Often spiteful/vindictive ☐ Deliberately sets fires ☐ Becomes tearful easily

☐ Refuses to go to school ☐ Lies often ☐ Often sad

☐ Repeated nightmares ☐ Steals ☐ Indecisive/can't think

☐ Unusual fears ☐ Has run away ☐ Thinks about death

☐ Panic attacks ☐ Extreme mood swings ☐ Talks about suicide

☐ Self-conscious/clings ☐ Does not show emotions ☐ Hurts self

☐ Excessive need for reassurance ☐ Overreacts to touch/noise ☐ Currently uses drugs

- ☐ Self-injurious behavior
- ☐ Worry of future events
- ☐ Repeats certain actions
- ☐ Somatic complaints (headache/stomach)
- ☐ Difficulty maintaining friendships
- ☐ Strange to bizarre ideas
- ☐ Used drugs in the past
- ☐ Poor social interactions
- ☐ Gets upset by changes in routine
- ☐ Currently drinks beer or alcohol
- ☐ Used beer or alcohol in the past
- ☐ Can't stop thinking about things
- ☐ Excessive preoccupation with objects or ideas

Please place a check mark in the column which best describes the child:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities	☐	☐	☐	☐
Often has difficulty sustaining attention in tasks or play activities	☐	☐	☐	☐
Often does not seem to listen when spoken to directly	☐	☐	☐	☐
Often does not follow through on special instructions and fails to finish schoolwork or chores (not due to oppositional behavior, but due to failure to understand directions)	☐	☐	☐	☐
Often has difficulty organizing tasks and activities	☐	☐	☐	☐
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)	☐	☐	☐	☐
Often loses things necessary for tasks or activities (toys, school assignments, pencils or books)	☐	☐	☐	☐
Is often easily distracted by extraneous stimuli	☐	☐	☐	☐
Is often forgetful in daily activities	☐	☐	☐	☐
Often fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
Often leaves seat in classroom or in other situations in which remaining seated is expected	☐	☐	☐	☐
Often runs about or climbs excessively in situations where it is inappropriate (in adolescents, it may be limited to subjective feelings or restlessness)	☐	☐	☐	☐
Often has difficulty playing or engaging in leisure activities quietly	☐	☐	☐	☐
Is often "on the go" or often acts as if "driven by a motor"	☐	☐	☐	☐
Often talks excessively	☐	☐	☐	☐
Often blurts out answers before questions have been completed	☐	☐	☐	☐
Often has difficulty waiting their turn	☐	☐	☐	☐
Often interrupts or intrudes on others (butts into conversation or games)	☐	☐	☐	☐

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

Your name_____ **Relationship to child**_____

Date: _____/_____/_____

Additional Patient Information:

Referred By: _____ (May we thank them for the referral? Y/N)

Females only (if applicable):

Date of first menstrual cycle: _____ Date of last menstrual cycle: _____

Painful Menstruation: ☐ Yes ☐ No

Previous Providers:

Midwife/Obstetrician: _____

Pediatrician/Family MD: _____

Date of last visit: ____/_____/_____ Purpose:_____

Immunization History: _____

Number of doses of antibiotics your child has taken: During the past 6 months _____ During lifetime _____

Has your child been to a chiropractor before?: ☐ Yes ☐ No

If yes, who was the physician?: _____

Reason for leaving: _____

Is your child currently seeing any other physician or healthcare professional?: ☐ Yes ☐ No

If Yes, who is the provider: _____

Date of last visit: _____/_____/_____ Reason for visit: _____

Renew Chiropractic, PLLC
1520 Huguenot Rd., Suite 113 ● Midlothian, VA 23113 ● p: (804)419-9290 ● F: (804)419-9291
www.renewchiropracticrva.com