PEDIATRIC HEALTH ASSESSMENT (3 years +)

Name: _____ Date of Birth:_____

Purpose for Contacting our Office:
_____
_____

PRENATAL HISTORY:
Type of Delivery: Vaginal _____ Cesarean _____
Complications of Delivery: _____
Interventions: Forceps _____ Vacuum Extraction _____

FEEDING:
Allergies or Intolerances: _____
Vitamins:_____

HEALTH HISTORY:
Does your child complain of pain or discomfort? _____
Was onset sudden or gradual? _____When did it start?_____
Any recent falls or injuries?_____
Has the child had this problem before? _____
Has the child been treated by a chiropractor before? _____
Any medical treatment for current complaint? _____
Surgeries? _____
Vaccinated? _____
Regular Medications? _____
Ear Infections? _____What age did they start _____
More in right or left ear?_____
Asthma? _____
Bedwetting? _____
Any other health issue or illness (please list date of occurrence)_____
_____
_____

DEVELOPMENTAL HISTORY: At what age did your child start to sit up? _____
Cross Crawl? _____ Stand Alone?_____ Walk? _____

Do you have any other concerns about your child's health or development?
_____
_____
_____