INNER STRENGTH CHIROPRACTIC
1522 State Street, Santa Barbara, California 93101 · (805) ON-LEVEL · www.ISChiro.com

Pediatric Health History

Today's Date: _____/_____/_____

Patient's Name: _____
Address: _____
City & State: _____ Zip: _____
Birth Date: _____/_____/_____ Age: _____
Height/Length: _____ Weight: _____
Gender: M F

Parent's:
Home Phone:_____
Work Phone: _____
Cell Phone: _____

Parents' Names & Ages: _____
Names & Ages of Siblings:_____
_____

Are the other members of your family Under Chiropractic Care? Y N
For What Reason?_____
How Did You Hear About Us? _____
Has your child ever been to a chiropractor before? _____ If so, when? _____

Past Health History

How Much Birth Trauma Did Your Child Experience? (Please circle all that apply)

Long Delivery?	Difficult Delivery?	Induced Labor?	Hospital birth?
Forceps Used?	Vacuum Extraction?	Caesarian Section?	Breech/cephalic presentation?
Mother given drugs?	Vaccines within first 3 years of life?		

Circle any conditions your child currently has or previously has had.

AIDS/HIV	Emphysema	Gout	Pinched Nerve	Tonsillitis
Arthritis	Cataracts	Heart Disease	Pneumonia	Scarlet Fever
Asthma	Chemical Dependency	Hepatitis	Polio	Tumors or Growths
Anemia	Chicken Pox	Liver Disease	Pacemaker	Typhoid Fever
Anorexia	Cold/Flu	Measles	Parkinson's Disease	Ulcers
Appendicitis	Goiter	Herpes	Psychiatric Care	Vaginal Infections
Bulimia	Gonorrhea	High Cholesterol	Rheumatoid Arthritis	Vision Problems
Cancer	Epilepsy	Kidney Disease	Rheumatic Fever	Viral Infections
Bleeding	Fibromyalgia	Migraines	Prostate Problem	Tuberculosis
Breast Lump	Glaucoma	Multiple Sclerosis	Stroke	Whooping Cough
Bronchitis	Hearing Problems	Mumps	Suicide Attempt	
Diabetes	Hernia	Osteoporosis	Tooth Problems	
Ear Infections	Herniated Disc	Mononucleosis	Thyroid Problems	

Other _____

INNER STRENGTH CHIROPRACTIC
1522 State Street, Santa Barbara, California 93101 · (805) ON-LEVEL · www.ISChiro.com

Describe the prenatal care:

How long was delivery?

Did the delivery include: Hospital Midwife Doula

Do you know your baby's APGAR Score?

Does your child experience any sleeping problems? Y N
If so, please explain_____
Child's sleeping posture: Stomach Back Other
Describe your child's diet: _____

Please list any surgeries, traumas, fractures, etc.

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Has Your Child Experienced Side Effects From Drugs and/or Surgery?

Exercise	Daily Activity	Habits
None Moderate Daily Sports Weight Lifting Other: _____	Sitting _____ Hrs/Day Standing _____ Hrs/Day Physical Activity _____ Hrs/Day Technology_____ Hrs/Day Other _____ _____	Coffee/Caffeine Cups/Day _____ High Stress? _____ Reason for Stress: School Physical Mental Emotional _____ Other _____

Medications & Supplements

Please list all **current** medications, vitamins, and other dietary supplements:

Please list all **past** medications, vitamins, and other dietary supplements:

INNER STRENGTH CHIROPRACTIC
1522 State Street, Santa Barbara, California 93101 · (805) ON-LEVEL · www.ISChiro.com

Do your child experience any sleeping problems? (including nightmares)? Y N
What is their sleeping posture: Side Stomach Back
What percentage of their food is: Organic?_____ Conventional? _____ GMO? _____ Processed/Packaged? _____
What percentage of their produce is from: Farmer's Market?_____ Health Food Store? _____
Grocery Store (eg. Vons, Albertson's, Ralph's)? _____
What percentage is: Frozen?_____ Canned? _____ Powder, Capsule, or Drink? _____
How often do they eat meat? _____
What kind of meat do they typically eat? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Family	○	○	○	○	○
Mother's Family	○	○	○	○	○

Current Health Condition

What is the reason for your child's visit today?
_____
Besides visiting our office today, what other steps are you taking to maximize their health and wellness?
_____
If you are here for Pain or a Problem, when did it start?
_____
Does it feel: Sharp Dull Constant Intermittent
What activities make your condition or pain better or worse? `_____
Is condition worse during certain times of the day? _____
Is this condition interfering with their: Work Sleep Daily Routine Other _____
Is this condition getting: Worse Better The Same
What type of care have they already received for your condition?
Chiropractic Massage Medication Surgery Other _____
Name of Doctor(s) who have cared for your child: _____
_____

Other Current Health Concerns (Please circle all that apply):

Neck Pain or Stiffness	Low Back Pain	Nervousness	Ringing / Buzzing in Ears
Headache	Hip or Groin Pain	Tension	Cold or Fever
Shoulder Pain	Leg Pain R L	Irritability	Fainting
Upper or Mid-Back Pain	Pins & Needles: Legs R L	Depression	Loss of Balance
Chest Pains	Numbness in Toes	Fatigue	Diarrhea
Rib Problems	High or Low Blood Pressure	Cold Sweats	Constipation
Arm or Hand Pain R L	Allergies	Face Flushed	Upset Stomach
Pins & Needles: Arms R L	Dizziness	Shortness of Breath	Other_____
Numbness in Fingers	Sleeping Problems	Memory Loss	_____

What Benefits of Chiropractic Care Would You Like to Achieve? (Please check all that apply)

- ○ Relieve Pain Quickly
- ○ Recovery from Injury or Disease
- ○ Help My Child Resist Injury or Disease
- ○ Avoid Drugs and/or Surgery
- ○ Improve My Child's Spinal & Nervous System Health
- ○ Live a Longer, Healthier, Happier Life
- ○ Live a More Vitalistic, Holistic Life
- ○ Improve My Performance in Physical Activities
- ○ Remain Active Longer