Miceli Family CHIROPRACTIC

PEDIATRIC HEALTH PROFILE

Today's Date_____

First Name_____ Last Name_____
Address_____
City:_____ Postal Code_____ Phone #:_____
Parents' name: _____
Email address (for appointment reminders): _____
Present Medical Doctor _____
Date of Last MD visit and reason: _____
Present length/height: _____ Present Weight: _____
Date of Birth: _____ AGE: _____ **AHC #:** _____
Gender **M F**

HEALTH HISTORY

Chief Health Concerns (why have you brought them in):_____
_____
_____
_____
List other types of care undergone for this complaint (including medications): _____
_____
Date of onset: _____ Onset was: ☐ Sudden ☐ Gradual ☐ Associated with an event
Duration of problem (episode): ☐ minutes ☐ hours ☐ days ☐ months ☐ years
Initiating factors: _____Aggravating factors: _____
Relieving factors: _____ Prior occurrences or episodes: _____
Effects of problems on body function and daily activities: _____
_____
Other health concerns: _____
_____

HISTORY OF BIRTH

☐ Hospital ☐ Birthing Centre ☐ Home ☐ Midwife
Duration of Gestation: _____weeks Assisted birth: Yes ☐ No ☐ If yes: ☐ forceps ☐ vacuum extraction ☐ c-section ☐ induced labor
Medications delivered to mother at birth? ☐ No ☐ Yes If yes, what? _____
Duration of birth: _____ Complications at birth: ☐ No ☐ Yes If yes, explain: _____
Was delivery normal? ☐ Yes ☐ No: _____
APGAR at birth: _____ Birth weight: _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? ☐ Yes ☐ No
If No, explain: _____
At what age did the child: Respond to sound: _____ Follow an object: _____ Hold head up: _____
Vocalize: _____ Sit alone: _____ Teethe: ____Crawl: ____ Walk: _____
Do your child's sleeping patterns seem normal to you: ☐ Yes ☐ No Explain: _____
Head turn preference? R L Any flat spots on the baby's head? Yes NO

Since problems that Chiropractors concern themselves with can be related to many types of stressors, the following is also very important to us:

CHEMICAL STRESSORS

Was (is) this baby breast-fed? ☐ Yes ☐ No – If yes, for how long? _____
Formula introduced at what age? _____ Type of formula used: _____
Introduction of cow's milk at age: _____ Began solid foods at age: _____ Type: _____
Food / Juice intolerance: ☐ No ☐ Yes Type: _____
During pregnancy did the mother: Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Any illness of the mother during the pregnancy? _____
Any supplements taken during pregnancy? _____
Any drugs taken during pregnancy? _____
Any exposures to ultrasound? ☐ No ☐ Yes - if so, how many and for what medical reason?
_____
Any invasive procedures (amniocentesis, CVS)? _____
Any pets at home: ☐ Yes ☐ No Any smokers in the home? ☐ No ☐ Yes - How much? _____
Any vaccinations? ☐ No ☐ Yes – Which ones and any reactions _____
Any antibiotics? ☐ No ☐ Yes Total # courses of antibiotics to date
_____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ☐ No ☐ Yes: _____
Any problems with bonding? ☐ No ☐ Yes: _____
Any behavioral problems? ☐ No ☐ Yes – Onset: _____
Any night terrors, sleep walking, difficulty sleeping? ☐ No ☐ Yes - Specify: _____

TRAUMATIC STRESSORS

Any trauma during pregnancy (falls, accidents)? _____
Any evidence of birth trauma? - bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other?: _____
Any falls from couches, beds, change tables: ☐ No ☐ Yes
Any trauma with bruising, cuts, stitches, fractures? ☐ No ☐ Yes
Any hospitalizations? ☐ No ☐ Yes - Explain: _____
Any surgeries or organs removed? _____
Sports played and age began: _____ Hours per week played: _____

Thank you for completing this form. Please write any other questions you have below:

_____
_____
_____
_____
_____

Thank you for choosing Miceli Family Chiropractic.