Child Health History

Child Name: _____ D.O.B. _____

Parent Name: _____

Address: _____

Phone Number: _____

Please check all that apply:

- ☐ Any illness during mother's pregnancy?
- ☐ Drugs/medicine/tobacco/alcohol in pregnancy?
- ☐ Labor chemical induced?
- ☐ Forceps/Vacuum Extraction/C-section
- ☐ Premature delivery?
- ☐ Vaccinations?
- ☐ Jaundice treatment?
- ☐ Colic?
- ☐ Eating or nursing problems?
- ☐ Sleeping problems?
- ☐ Falls in first year of life?
- ☐ Other falls or injuries?
- ☐ Respiratory problems?
- ☐ Allergy/Asthma?
- ☐ Ear infections?
- ☐ Digestive Problems?
- ☐ Hyperactivity?
- ☐ Poor nutrition?
- ☐ Auto accident injury?
- ☐ Sports injury?
- ☐ Family/Home stress?
- ☐ Prescription drug use?
- ☐ Non-prescription drug use?
- ☐ Ever hospitalized?
- ☐ Surgery? For what: _____
- ☐ Any major illness? _____
- ☐ Reoccurring illnesses?
- ☐ Limited exercise?
- ☐ Any other health related problems? Please list: _____

Anything else? (Surgeries/Traumas/Illnesses/Medications/Supplements/Other):

_____

_____

Diet/Food Intake:

☐ Fruits
☐ Vegetables
☐ Meat/Protein
☐ Nuts
☐ Seeds
☐ Water
☐ Other:

☐ Juice
☐ Soda
☐ Processed Foods
☐ Wheat
☐ Dairy

_____

_____

Doctor's Exam/Notes

Height: _____ Weight: _____

Vitals/Exam

Heart Sounds: WNL/Arrhythmia/Murmur/Other: _____

Lungs: WNL/Raspy/Wheezing/Other: _____

Lymph: WNL/Anterior Chain/Posterior Chain/Suboccipital/Subclavian/Other: _____

Eyes: Pupillary Reflex: Equal/Unequal Light Reflex: WNL/Other: _____

Ears: Clear/Wax/Blood/Puss/Swelling/Other: _____

Nose: WNL/Other: _____

Throat: WNL/Red/Swollen Tonsils/Other: _____

Head Tilt Lateral/Rotation: Left/Right/Both/None

Shoulders: High/Low Left/Right

Knees: Knock/Pigeon Toed/Rickets Left/Right/Both/None

Orthopedic Exam

Valsalva's: Negative/Positive LT/RT

SLR: Positive/Negative LT/RT

Braggard's: Negative/Positive LT/RT

Anterior Drawer: Positive/Negative LT/RT

Posterior Drawer: Positive/Negative LT/RT

Forminal Compression: Positive/Negative LT/RT