Miller Chiropractic Health Center

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CHILD HISTORY FORM - Nutrition

Please answer the questions on this form as completely as possible. If you need assistance, please ask at the front desk, and we will be happy to assist you.

Child's Name: _____ Today's Date: _____
Gender: M F Date of Birth: ____/____/____ Age: _____
Siblings' Name(s) and Age(s): _____
Street Address: _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Primary Phone #: _____ (please indicate whose phone this is) Secondary Phone #: _____
E-mail address: _____
Who may we thank for referring you to our office?_____
Name of medical doctor: _____
Date and reason for last MD visit: _____
Do you wish to grant Miller Chiropractic Health Center physicians permission to share/discuss medical findings with your other healthcare providers (i.e. MD, DO, etc.) if they deem necessary? □ Yes □ No

RESPONSIBLE PARTY:
Parent or Guardian Name(s): _____ Date of Birth: _____/_____/_____
Relationship to Patient: _____
Street Address (if different from child's) : _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Primary Phone #: _____ Secondary Phone #: _____
E-mail address (if different from child's): _____
Employer Name: _____ Occupation of parents/guardians:_____

PRESENT HEALTH COMPLAINTS/CONCERNS

Please list your child's health concerns according to their severity:

Please list your health concerns according to their severity.	Rate of severity 1 = mild 10 = worst imaginable	When did THIS episode start?	If you had this condition before, when?	% of the time the pain/symptom is present
1.				
2.				
3.				
4.				
5.				

What makes this worse? _____
What makes this better? _____
Does the problem interfere with the child's sleep? _____ Eating? _____ Play? _____
Is the child's daily routine affected? _____
Is this: □ Getting better? □ Getting worse? □ Stationary?
Other professionals seen for this condition: _____
Results with any treatment(s): _____
_____
What phrase MOST represents your child's reason for care today: □ wellness/prevention □ feel good/symptom relief

PREGNANCY & BIRTH HISTORY

Gestational Duration: _____ weeks Birth weight: _____ lbs. _____ oz. Birth length: _____

PHYSICAL STRESS

Trauma/falls during Pregnancy?_____

Any ultrasounds or other radiation? ☐ Yes ☐ No
How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis, CVS)? ☐ Yes ☐ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ☐ Yes ☐ No How Much? _____
Drink Alcohol? ☐ Yes ☐ No How Much? _____
Prescription Medications? ☐ Yes ☐ No Please List _____
Recreational Drugs? ☐ Yes ☐ No How Much? _____
Fall ill during pregnancy? ☐ Yes ☐ No Please Explain _____
Have amalgam fillings? ☐ Yes ☐ No How Much? _____
Receive vaccinations? ☐ Yes ☐ No Which ones? _____
Have chemical exposures (cleaning chemical spills, working at a salon?) ☐ Yes ☐ No Please Explain_____
Have dental work done? ☐ Yes ☐ No How Much? _____
Was your child's birth: ☐ at home ☐ in a birthing center ☐ in a hospital Duration of labor and birth: _____ hours
Were there any complications to the delivery? If yes, please explain: _____

_____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10, 10=high: _____
Did mother have any difficulties with breastfeeding? ☐ Yes ☐ No
Did mother and baby have difficulty bonding? ☐ Yes ☐ No
Did mother experience post-partum depression? ☐ Yes ☐ No

LABOR & BIRTH

Please check any form of assistance that was used during delivery:

☐ Forceps ☐ Vacuum extraction ☐ Cesarean ☐ Episiotomy

Was labor: ☐ spontaneous ☐ induced APGAR Scoring: at birth _____/10 after 5 minutes _____/10
Were medications or epidurals given to the mother during birth? If yes, what was given? _____

_____

Did your child spend any time in intensive care? ☐ Yes ☐ No How long?

_____

Was your child subjected to any of the following? ☐ separation from mom _____how long
☐ silver nitrate drops in eyes ☐ vitamin K shot ☐ hepatitis B shot ☐ incubation _____how long

CHILDHOOD HEALTH HISTORY

PHYSICAL STRESS

Did your child prefer one-sided breast-feeding position? ☐ Yes ☐ No
Did your baby spit up after feeding? ☐ Yes ☐ No
Any falls or injuries down stairs, bicycle etc.? ☐ Yes ☐ No
Does child ever bank his/her head repeatedly? ☐ Yes ☐ No
Did your child have colic as an infant? ☐ Yes ☐ No
Please list any accidents and/or injuries: auto, sports, or other (especially those related to your child's present problems)

1. Type_____ When?_____ Hospitalized? ☐ Yes ☐ No
2. Type_____ When?_____ Hospitalized? ☐ Yes ☐ No
3. Type_____ When?_____ Hospitalized? ☐ Yes ☐ No

Please list all surgeries your child has had:

1. Type_____ When?_____
2. Type_____ When?_____
3. Type_____ When?_____

CHEMICAL STRESS

Was/is the child breast-fed □ Yes □ No How long? _____

Formula introduced? _____ Brand? _____

Cow's milk introduced? □ Yes □ No

Solid food introduced? □ Yes □ No If just starting, please list _____

Food/juice intolerance? □ Yes □ No Please Explain _____

Does your child have food allergies? □ Yes □ No Please list _____

Do you have a water filtration system? □ Yes □ No What kind? _____

…for your tub or shower? □ Yes □ No What kind? _____

Is your child in a home that smokes? □ Yes □ No

What is your child's favorite food? _____

What does your child regularly drink? _____

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

- **D** consume this daily
- **FD** consume this a few times daily
- **W** consume this weekly
- **FW** consume this a few times weekly
- **M** consume this monthly
- **FM** consume a few times per month
- **0** do not consume this

Eggs	_____	Fasting/skipping meals	_____	Fruit	_____	Sugar	_____
Fish	_____	Weight Control Diet	_____	Organic Food	_____	Poultry	_____
Coffee	_____	Artificial sweetener	_____	Raw Vegetables	_____	Canned Food	_____
Beef	_____	Cooked Vegetables	_____	Whole Grains	_____	Fast Food	_____
Dairy	_____	Packaged Foods	_____	Soft Drink	_____		

Does your child have a bowel movement every day? □ Yes □ No _____

Does your child have regular or occasional skin rashes? □ Yes □ No _____

What vaccinations were given and at what age?

Vaccine	Age	Vaccine	Age
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Reason for vaccinations _____

Were there any negative reactions? _____

Was there any: □ Fever □ Irritability □ Bowel Disturbances □ Drowsiness □ Un-consolable crying

□ Arching of body □ Feeding disturbances □ Other _____

History of antibiotics? □ Yes □ No If so, how many courses has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

PATIENT NAME: DOB: DATE:

Does your child have any tattoos? □ Yes □ No
Are there smokers in the home? □ Yes □ No
Has your child had any dental fillings? □ None □ Tooth Colored □ Amalgam/silver colored □ Placed by biological dentist?
Has your child had any dental work done besides routine cleanings? Please explain_____
Does your child live on or near a farm or near a golf course? _____
How old is the house you are living in? _____ How long have you lived there? _____
Do you see mold growing at home or school? □ Yes □ No
Have you ever had water damage at home or school? □ Yes □ No
Does your child's home or school have a damp or mildew smell? □ Yes □ No
Does spending time in your basement cause or worsen symptoms? □ Yes □ No
Does spending time in a different location for at least a few days cause a noticeable decrease in symptoms? □ Yes □ No
Please list any health conditions your child has been diagnosed with _____
Are there any known drug allergies? _____

Medications:

Medications your child currently takes or has taken in the past 6 months.	How long has your child taken this?
1.	
2.	
3.	
4.	

Vitamins/Supplements/Homeopathic Remedies

Supplements	How long has your child taken this?
1.	
2.	
3.	
4.	

EMOTIONAL STRESS

Does your child appear to be stressed on a regular basis? □ Yes □ No
Any known childhood traumas? □ Yes □ No
Any thoughts of suicide? □ Yes □ No

Sleep Habits:

How well does your child sleep? □ Well □ Trouble falling asleep □ Trouble staying asleep □ Insomnia
Does your child wake up tired? □ Yes □ No
Does your child take naps? □ Yes □ No
Does your child have night terrors or sleep walk? □ Yes □ No
How many hours does your child sleep in an average night? _____

Family History:

Describe any medical family history on mom's side: (cancer, diabetes, etc…) _____
_____
On father's side: _____
Does siblings have any health concerns? □ Yes □ No Please describe_____
_____

PATIENT NAME: DOB: DATE:

FOR CYCLING FEMALES ONLY

1. Age of onset of menarche (first period) _____
2. Is your child currently using any method of birth control? ☐ Yes ☐ No
   If so, what kind? ☐ Oral pill ☐ Injected ☐ Patch ☐ Ring
   How long has your child been using birth control _____
3. Please describe any symptoms that your child may have experienced wile on birth control (i.e. yeast infections, heavy/light bleeding, moodiness, weight gain, acne, sweet cravings palpitations, fatigue): _____
4. First day of last period: _____ Length of typical period: _____
5. Is menstrual cycle regular? ☐ Yes ☐ No ☐ Not always
6. Any knowledge of passing clots? ☐ Yes ☐ No
7. Any spotting between periods? ☐ Yes ☐ No
8. What PMS symptoms does your child have? _____
9. Is your child sexually active? _____

Authorization for Care of a Minor Child Under 18 Years of Age

I hereby authorize and consent to the nutritional evaluation of my child, _____

Parent(s) _____ Contact Phone #: _____
Parent/Guardian Signature: _____ Date: _____

NUTRITIONAL INFORMED CONSENT: Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Any suggested nutritional advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I have read and understand the above.

Patient's or authorized person's signature: _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

FINANCIAL POLICY/COMMUNICATION POLICY: I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I give Miller Chiropractic Health Center and its representatives permission to communicate to me via the contact information above.
Patient's or authorized person's signature: _____ Date _____

I ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, AND UNDERSTAND AND AGREE TO THE *Notice of Privacy Practices* of Miller Chiropractic Office, PA, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.
Parent's signature: _____ Date: _____

I give permission for the following persons to have full access to my minor child's medical records:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

PATIENT NAME: DOB: DATE: