PORTLAND
CHIROPRACTIC · NEUROLOGY

Account Information

If you need any assistance completing this paperwork, please ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

CONFIDENTIAL HEALTH INFORMATION
Clinic ID: Date:

Patient Information

Last name First name MI Prefer to be called

Is child here because they were injured in a motor vehicle collision, or in another accident? ☐ Yes ☐ No

Health Complaints

*What is your child's **primary** complaint?* _____

How long has child been experiencing this primary complaint? _____

Has this progressed over that time? _____

*Using the scale below, rate how child's **primary** complaint affects his/her life (mark only one box)*

1	2	3	4	5	6	7	8	9	10
Symptoms that do not affect life in any way	Symptoms that slightly affect life	Symptoms that don't affect daily activities	Symptoms that affect daily activities	Symptoms prevent performing daily activities	Symptoms that limit school schedule	Symptoms that prevent attending school	Symptoms that prevent school and all personal activities	Symptoms that keep child from leaving home	Symptoms that cause thoughts of suicide

Does child have any additional symptoms (musculoskeletal, neurological, or otherwise) that are related to this?

If yes, please list: _____

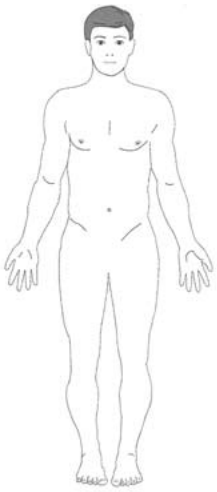
List any other health conditions/complaints child is currently experiencing on the following lines:

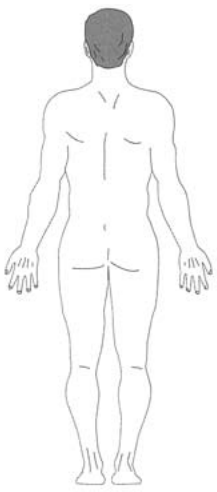
1) _____ 2) _____

3) _____ 4) _____

Please use the images on the right to mark the areas affected by your chief complaint and any of the associated symptoms listed above.

Include any additional descriptors or comments concerning your health complaints if necessary.





Last Name, First Initial:_____

Lifestyle & Nutritional Habits

❖ Schooling History:

Does child currently attend school? ☐Yes ☐No, unable to attend ☐Homeschooled ☐N/A

*If yes, list grade and any accommodations received (if applicable):*_____

❖ Daily Habits:

On average how many hours of television does child watch per day?	☐<1	☐1-3	☐3-5	☐>5
On average, how many hours per day does child use a computer at school or home?	☐<1	☐1-3	☐3-5	☐>5
On average, how many hours per day does child ride in a car or other vehicle?	☐<1	☐1-3	☐3-5	☐>5
Does child exercise?	☐Yes	☐No		
If yes above, how often does child exercise?	☐Daily	☐3-5x/wk	☐2x/wk	☐1x/wk
On average, how long do child's workouts last?	☐>1hr	☐1hr	☐30min	☐<30min

What are child's exercise activities? (mark all that apply)

☐Walking	☐Swimming	☐Weight lifting
☐Stretching/Flexibility	☐Yoga/Pilates	☐Resistance bands
☐Running/elliptical/rowing/stairclimbing	☐Group Exercise Class	☐Athletics_____

❖ Dietary Habits:

How many servings of juice does child drink per week?	☐0	☐1-2	☐3-5	☐>5
How many servings of sports drinks does child drink per week?	☐0	☐1-2	☐3-5	☐>5
How many servings of soda does child drink per week?	☐0	☐1-2	☐3-5	☐>5

What does your child's diet primarily consist of? (mark all that apply)

☐Breads, cereals	☐Pastas, rice	☐Cookies, crackers, pretzels
☐Lean protein (chicken, beef, fish)	☐Dairy (milk, cheese, ice cream)	☐Vegetables
☐Processed meats (lunch meat, etc)	☐Processed/packaged snacks/meals	☐Fruits
☐Candy	☐Soda/energy & sugary drinks	☐Coffee/tea
☐Water		

❖ Dietary Habits cont'd:

What is your child's attitude about food/eating? (mark all that apply)

- ☐ Eat 3 full meals per day
- ☐ Eat less than 3 full meals per day
- ☐ Snack often throughout the day
- ☐ Eat balanced meals
- ☐ Do not eat balanced meals
- ☐ Very picky about foods
- ☐ Overeat at each meal
- ☐ Is hungry soon after each meal
- ☐ Prefer snacking over meals
- ☐ Enjoy eating
- ☐ Poor appetite for food in general

Family Health History

Mark the following conditions as they pertain to child's family. Include family member (parents,siblings,grandparents)

Diabetes	_____	Cancer	_____
Heart problems	_____	Vascular problems (including stroke, embolism)	_____
Kidney problems	_____	Muscle diseases (myopathies)	_____
Gastrointestinal problems	_____	Nerve diseases (neuropathies)	_____
Autoimmune conditions	_____	Neurological conditions	_____
Respiratory conditions	_____	Psychiatric conditions (i.e. depression, bipolar, schizophrenia, etc)	_____
Musculoskeletal conditions	_____	Headaches	_____
Other	_____		

Does any member of child's family have a condition/symptoms similar to theirs? ☐ Yes ☐ No

*If yes, please explain:*_____

Medical History

Mark any of the following conditions as they pertain to your child

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Measles
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Psychiatric Disorders
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Venereal Infection
- ☐ Whooping Cough

*Any cardiac conditions? (if yes, please explain)*_____

Any significant illnesses or infections in child's past? (if yes, please explain) _____

❖ Medical History cont'd:

Any recent illnesses or infections? (if yes, please explain) _____

Any known allergies or sensitivities? (please describe) _____

Any autoimmune conditions? (thyroid disorders, eczema, psoriasis, RA, Lupus, etc.) _____

List any broken bones or dislocations your child has had (include locations, R/L) _____

Has child suffered any head injuries (including concussions)?	☐ Yes	Please explain:_____
Was child ever knocked unconscious?	☐ Yes	Please explain:_____
Has child ever had a lapse in memory?	☐ Yes	Please explain:_____
Has child ever had a spinal tap or injection?	☐ Yes	Please explain:_____

❖ Surgical History:

Does child have any implantable medical devices in their body? (including pacemakers, stents, plates, screws)

If yes, please explain: _____

Mark all of the following procedures as they pertain to child: (for procedures listed in 3rd column, please describe on adjacent line)

☐ Tonsillectomy	☐ Thyroid surgery	☐ Neurosurgery	_____
☐ Gall bladder removal	☐ Stomach surgery	☐ Spinal surgery	_____
☐ Appendectomy	☐ Rectal surgery	☐ Cardiac surgery	_____
☐ Hernia repair	☐ Abdominal surgery	☐ Orthopedic surgery	_____
☐ Breast implant surgery	☐ Tubes in ears	☐ Female surgery	_____
☐ Cesarean Section	☐ Knee/hip replacement	☐ Male Surgery	_____
		☐ Other	_____

❖ *Medications, Vitamins, Supplements*

Please list any *vitamins or supplements* child is currently taking:

_____ _____ _____

_____ _____ _____

Please list any *prescription or over-the-counter medications* child is currently taking and the condition for which child is taking them:

_____ _____ _____

_____ _____ _____

Injuries

❖ *List any (even minor) motor vehicle collisions (auto or otherwise), that child has been involved in as either driver or passenger, begin with most recent*

Type of collision	Injuries suffered & treatment received	Date of injury
_____	_____	_____
_____	_____	_____
_____	_____	_____

❖ *List any athletic injuries that child has experienced below. Begin with the most recent*

Type of injury	Treatment received	Date of injury
_____	_____	_____
_____	_____	_____
_____	_____	_____

❖ *List any other injuries that child has experienced below. Begin with most recent*

Type of injury	Treatment received	Date of injury
_____	_____	_____
_____	_____	_____
_____	_____	_____

Gestational/Developmental History

❖ Gestational History

Was the child's mother sick during pregnancy at all? (If yes, please explain)_____

Was the child healthy throughout the pregnancy? (If not, please explain) _____

Was the child full term/born on time? (If not, please explain) _____

What type of delivery did child's mother have?

☐Vaginal birth	☐Scheduled Cesarean Section	☐Emergency Cesarean Section
☐Assisted birth (forceps)	☐Assisted birth (suction)	☐Child was breech
☐Birth was induced	☐Other, please explain	_____

Was the child healthy at birth? Please explain (cord wrapped, not breathing, jaundiced, injuries, infections, etc)

_____

Were child's APGAR tests normal? (*If any irregularities, please explain)*_____

*How much did the child weigh at birth?*_____

❖ Gestational History cont'd

Were child or mother hospitalized following birth for any reason? (If yes, please explain)_____

*Any other comments or concerns regarding mother's pregnancy?*_____

*Any other comments or concerns regarding child's birth?*_____

❖ Developmental History

Was/Is child sick often? (If yes, please explain)_____

Are you aware of any milestones that the child may have skipped over (i.e. crawling, rolling over)? If yes, please describe below

_____

Are you aware of any milestones that the child reached, but progressed through rapidly? *If yes, please describe below*

_____

Are you aware of any milestones that the child reached earlier or later than their peers? If yes, please describe below

_____

Does the child have any problems with wetting/soiling? (If yes, please explain) _____

Did the child crawl normally? (i.e. hands, knees with cross patterning) ☐Yes ☐No

If Yes, what approximate age did they develop this?

☐Before 6 months ☐6 months ☐6 months - 1 year
☐1-1.5 years ☐1.5-2 years ☐Unknown
☐Other: _____

How long did this last? (#weeks, #months, etc.) _____

When did the child begin walking? If applicable

☐Before 8 months ☐8 months - 1 year ☐1-1.5 years
☐1.5-2 years ☐2-2.5 years ☐Unknown
☐Other: _____

When did child begin to speak first words? If applicable

☐Before 8 months ☐8 months - 1 year ☐1-1.5 years
☐1.5-2 years ☐2-2.5 years ☐Unknown
☐Other: _____

When did child begin to speak short phrases? If applicable

☐Before 8 months ☐8 months - 1 year ☐1-1.5 years
☐1.5-2 years ☐2-2.5 years ☐Unknown
☐Other: _____

❖ Developmental History cont'd

What is/was the child's gross/general motor development like between the ages of 2-5 years?
(running, jumping, throwing, etc.)

- ☐ Average in comparison to other children their age
- ☐ More advanced in comparison to other children their age
- ☐ Delayed in comparison to other children their age
- ☐ Other: _____

What is/was the child's fine motor development like between the ages of 2-5 years?
(holding crayons, picking up small objects, buttoning, etc.)

- ☐ Average in comparison to other children their age
- ☐ More advanced in comparison to other children their age
- ☐ Delayed in comparison to other children their age
- ☐ Other: _____

What is/was their social development like between the ages of 2-5 years?
(relationships with adults, authority figures, relationships with peers, siblings, development of friendships)

- ☐ Average in comparison to other children their age
- ☐ More advanced in comparison to other children their age
- ☐ Delayed in comparison to other children their age
- ☐ Other: _____

What is/was their mental development like between the ages of 2-5 years?
(counting, knowledge of colors, alphabet, puzzle-solving, understanding concepts)

- ☐ Average in comparison to other children their age
- ☐ More advanced in comparison to other children their age
- ☐ Delayed in comparison to other children their age
- ☐ Other: _____

If the child is in school, do they have any particular areas of interest?

- ☐ Art
- ☐ Arithmetic
- ☐ Geometry
- ☐ Gym
- ☐ History/Social Studies
- ☐ Music
- ☐ Reading
- ☐ Science
- ☐ Spelling

Describe child's favorite activities to do in their free time:
(i.e.play outdoors, play team sports, watch TV/movies, play games on computer/tablet, paint, etc.)

_____

_____

Last Name, First Initial:_____

Review of Systems

Mark any of the following conditions/symptoms that currently pertain to the child

❖General

☐Consistent fainting	☐Chills	☐Convulsions	☐Depression	☐Dizziness
☐Loss of weight	☐Fatigue	☐Fever	☐Headaches	☐Loss of sleep
☐Weight gain	☐Neuralgia	☐Night sweats	☐Wheezing	☐Nervousness

❖ Gastro-Intestinal

☐Constipation	☐Diarrhea	☐Gall bladder issues	☐Hemorrhoids	☐Poor digestion
☐Liver problems	☐Nausea	☐Stomach pain	☐Poor appetite	☐Changes in urgency
☐Rectal bleeding	☐Vomiting	☐Vomiting blood	☐Jaundice	☐Changes in frequency

❖ Eye/Ear/Nose/Throat

☐Asthma	☐Sore throat	☐Tonsillitis	☐Blurry vision	☐Earache
☐Ear noises (tinnitus)	☐Enlarged thyroid	☐Crossed eyes	☐Double vision	☐Ear discharge
☐Nasal obstruction	☐Nose bleeds	☐Worsening vision	☐Eye pain	☐Deafness
☐Hay fever	☐Sinusitis	☐Hoarseness	☐Changes in sense of smell	☐Changes in sense of taste

❖ Respiratory

☐Chronic cough	☐Chest pain	☐Difficulty taking normal breath	☐Difficulty taking deep breath	☐Wheezing
☐Heaviness in chest	☐Coughing blood	☐Coughing phlegm		

❖ Musculoskeletal

☐Backache	☐Foot pain	☐Pain between shoulder-blades	☐Painful tailbone	☐Neck stiffness
☐Spinal curvature	☐Loss of range of motion	☐Weakness	☐Changes in muscle tone	☐Muscle twitching
☐Muscle tremors	☐Swollen joints	☐Changes in gait		

❖ Cardio-Vascular

☐Ankle swelling	☐Poor circulation	☐High blood pressure	☐Low blood pressure	☐Heart fluttering/ palpitations
☐Rapid heartbeat	☐Slow heartbeat	☐Pain over heart	☐Venous insufficiency	

❖ Skin/Integumentary

☐Dryness	☐Bruise easily	☐Hives	☐Itching	☐Eczema
☐Sensitive skin	☐Skin discolorations	☐Thinning of skin		

❖ Neurological

☐Attention problems	☐Mental fogginess	☐Mental fatigue	☐Mood changes	☐Lack of motivation
☐Incoordination	☐Difficulty with word retrieval	☐Difficulty remembering names	☐Difficulty remembering faces	☐Difficulty expressing feelings
☐Difficulty recalling memories	☐Difficulty understanding directions	☐Difficulty with simple math calculations	☐Difficulty with comprehension	☐Difficulty finishing tasks
☐ Abnormal sensations	☐Uncontrollable movements	☐Increased anxiety or panic	☐Increased sensitivity to light	☐Increased sensitivity to touch
☐Increased sensitivity to sound	☐Easily get annoyed/ frustrated			

❖ *Please note any additional comments or concerns you would like us to know regarding your child's health*

❖ *I understand and agree to the following:*

❖ *It is my responsibility to complete the clinic's forms accurately and provide the most up to date information*

❖ *It is my responsibility to notify the doctor if any of the information has changed or requires updating*

Signature of patient Date

Signature of Guardian Relationship to patient Date