thrive
CHIROPRACTIC
OPTIMAL FUNCTION, OPTIMAL HEALTH

COMPREHENSIVE HEALTH PROFILE - CHILD

DATE: ______________________________

6080 Falls Road, Suite 200A, Baltimore, MD 21209 | PH: 443-991-4703 | FX: 443-558-3308

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________

Prefers to be called: ______________________ Weight: __________ Height: __________

Date of Birth: ______________ Age: ________ Favorite thing to do: ______________
MM/DD/YYYY

Names and ages of siblings: ______________________________

Parent/Guardian Name(s): ______________________________

Address: ______________________________

City/State: ______________ ZIP Code: __________ Phone Number: ______________

Email: ______________________________ Referred by: ______________

Our focus is on helping your child function optimally so that they are dynamic, healthier and better able to adapt to the stresses of everyday life. This form gives us diverse insight into your child's health history. Please complete the questions to the best of your ability, and if you are unsure or uncomfortable with any of the questions, please leave it blank and complete the rest of the form.

CURRENT HEALTH CONDITIONS

1. Please list any concerns that you have regarding the health of your child, then answer each question.

	PRIMARY CONCERN	SECONDARY CONCERN	OTHER CONCERN
When did this start?			
Have you had this problem before?			
What makes it better?			
What makes it worse?			
Is there a particular time of day that your symptoms are worse?			
Since this started is the problem better, worse or the same?			
Does this radiate or refer to any other part your body?			
Have you seen anyone else for this concern?			

COMPREHENSIVE HEALTH PROFILE - CHILD continued

NAME: ____

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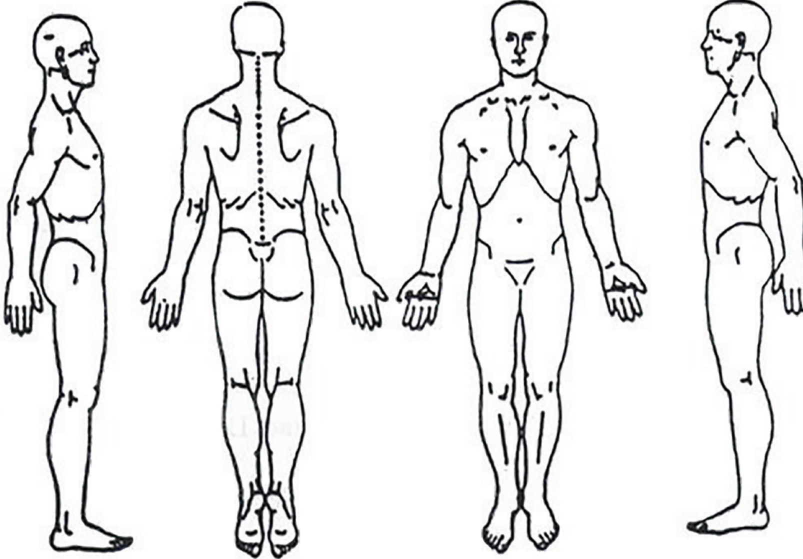
CURRENT HEALTH CONDITIONS

2. If your concern involves any physical sensations or characteristics please make note on the diagram below.



A = Aching
B = Burning
F = Stiffness
N = Numbness
P = Pins & Needles
S = Stabbing
T = Tension
O = Other

If OTHER, please explain:

____

____

____

PREGNANCY, BIRTH & INFANCY

3. Was your pregnancy planned? ❍ Yes ❍ No

5. Were you considered “High Risk” at any point? ❍ Yes ❍ No If so, why? ______________________

____

____

6. Was the baby in a breech position at any time during pregnancy? ❍ Yes ❍ No

7. How many weeks along were you at delivery? _________ weeks

9. Was the birth a vaginal delivery? ❍ Yes ❍ No

8. Did you have any medical interventions at birth? (e.g. inducements, pitocin, epidural, forceps, vacuum, extraction etc.) ❍ Yes ❍ No

   If so, please describe: ____

11. Please describe any other complications during pregnancy or delivery otherwise not mentioned:

____

____

____

12. Immediately after birth were there any health concerns regarding the baby? ❍ Yes ❍ No

13. Did you breastfeed? ❍ Yes ❍ No If so, for how long? ______________________

14. Overall, as a baby did your child rest well, eat well and eliminate well? ❍ Yes ❍ No

NAME: ____

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CHILDHOOD

15. Has your child experienced any of the following?

___ Fall from a changing table, crib or other height	___ Tonsillitis	___ Bed wetting
	___ Frequent crying spell	___ Hyperactivity/Autism
___ Involved in car accident	___ Frequent fevers	___ Asthma
___ Play in a Jolly Jumper or other seated type device	___ Frequent bouts of diarrhea	___ Allergies
	___ Constipation	___ Sleeping problems
___ Sports accident	___ Frequent colds	___ Colic
___ Growing Pains	___ Did not gain weight	___ Learning difficulties
___ Leg/knee pain	___ Stomach pains	___ Emotional Disorders
___ Frequent ear infections	___ Scoliosis	___ Other________________

Comments regarding the above: ____

16. Does your child seem unwilling or unable to participate in common childhood activities like running, climbing, jumping, playing or socializing with other children? ❍ Yes ❍ No Comments regarding the above:

____

____

____

17. Has your child ever been hospitalized? ❍ Yes ❍ No ______________________________

18. Has your child been prescribed antibiotics? ❍ Yes ❍ No Approximately How Many Times? ____________

19. Is your child currently on any medications or supplements (Please list type, reason and duration):

____

____

____

20. Other than birth has your child ever been hospitalized or had a surgery. ❍ Yes ❍ No

21. Has your child been to a Doctor of Chiropractic before? ❍ Yes ❍ No

If so, who:______________________________ and were x-rays taken: ❍ Yes ❍ No

22. Who is your regular pediatrician: ____

23. Is there anything else not mentioned on this form that you would like the doctor to know about your child:

____

____

____

____

____

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DETAILED REVIEW OF SYSTEMS

PATIENT NAME: ___________________________________

DATE: ___________________________________

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CARDIOVASCULAR ❑ N/A

Present	Past	
❑	❑	Chest Pain
❑	❑	Swelling of Legs
❑	❑	Poor Circulation
❑	❑	Irregular Heartbeat
❑	❑	High Blood Pressure
❑	❑	High Cholesterol
❑	❑	Heart Disease
❑	❑	Heart Attack
❑	❑	Aortic Aneurysm
❑	❑	Pacemaker
❑	❑	Other _______________

GENITOURINARY ❑ N/A

Present	Past	
❑	❑	Difficult Urination
❑	❑	Painful Urination
❑	❑	Frequent Urination
❑	❑	Blood in Urine
❑	❑	Kidney Stone
❑	❑	Kidney Disease
❑	❑	Prostate Problems
❑	❑	Erectile Dysfunction
❑	❑	Bed Wetting/Enuresis
❑	❑	Incontinence
❑	❑	Other _______________

HEMATOLOGICAL/LYMPHATIC ❑ N/A

Present	Past	
❑	❑	Bleeding Problems
❑	❑	Anemia
❑	❑	Swollen Lymph Nodes
❑	❑	Impaired Wound Healing
❑	❑	Recurrent Infection
❑	❑	Other _______________

RESPIRATORY ❑ N/A

Present	Past	
❑	❑	Difficulty Breathing
❑	❑	Shortness of Breath
❑	❑	Asthma
❑	❑	Upper Respiratory Infection
❑	❑	Cold/Flu
❑	❑	Pneumonia
❑	❑	Cough/Wheezing
❑	❑	Emphysema
❑	❑	COPD
❑	❑	RSV
❑	❑	Tuberculosis
❑	❑	Other _______________

EARS/NOSE/THROAT ❑ N/A

Present	Past	
❑	❑	Sinus Congestion
❑	❑	Sinus Infection
❑	❑	Nosebleed
❑	❑	Sore Throat
❑	❑	Difficulty Swallowing
❑	❑	Ear Ache
❑	❑	Ear Infections
❑	❑	Dizziness
❑	❑	Hearing Loss
❑	❑	Bleeding Gums
❑	❑	Other _______________

EYES ❑ N/A

Present	Past	
❑	❑	Glaucoma
❑	❑	Double Vision
❑	❑	Blurred Vision
❑	❑	Red, Itchy (Allergy)
❑	❑	Other _______________

ALLERGIC/IMMUNOLOGICAL ❑ N/A

Present	Past	
❑	❑	Autoimmune Disorder
❑	❑	Chronic Allergies
❑	❑	Eczema
❑	❑	Food Allergies
❑	❑	Environmental Allergies
❑	❑	Allergy Shots
❑	❑	Cortisone Use
❑	❑	HIV/AIDS
❑	❑	Hives
❑	❑	Weak Immune System
❑	❑	Other _______________

GASTROINTESTINAL ❑ N/A

Present	Past	
❑	❑	Pancreatitis
❑	❑	Acid Reflux
❑	❑	Bowel Problems
❑	❑	Constipation
❑	❑	Upset Stomach
❑	❑	Gas Pains
❑	❑	Ulcers
❑	❑	Gallbladder Problems
❑	❑	Liver Problems
❑	❑	Diarrhea
❑	❑	Nausea/Vomiting
❑	❑	Poor Appetite
❑	❑	Bloody Stools
❑	❑	Chrohn's Disease
❑	❑	Hiatal Hernia
❑	❑	Hemorrhoids
❑	❑	Other _______________

MUSCULOSKELETAL ❑ N/A

Present	Past	
❑	❑	Chronic Hip Dislocation
❑	❑	Torticollis
❑	❑	Poor Posture
❑	❑	Neck Pain
❑	❑	Back Pain
❑	❑	Arthritis
❑	❑	Rheumatoid Arthritis
❑	❑	Joint Stiffness
❑	❑	Muscle Weakness
❑	❑	Osteoporosis
❑	❑	Broken Bones
❑	❑	Joint Replacement
❑	❑	Gout

NEUROLOGICAL ❑ N/A

Present	Past	
❑	❑	Tic Disorder
❑	❑	Seizures
❑	❑	Head Injury
❑	❑	Brain Aneurysm
❑	❑	Numbness/Tingling
❑	❑	Pinched Nerves
❑	❑	Radiating Pain

NEUROLOGICAL cont'd ❑ N/A

Present	Past	
❑	❑	Sciatica
❑	❑	Parkinsons Disease
❑	❑	Carpal Tunnel
❑	❑	Balance/Coordination
❑	❑	ADHD/ADD/Sensory Processing Disorder
❑	❑	Autism/Spectrum Disorder
❑	❑	Migraine Headaches
❑	❑	Sinus Headache
❑	❑	Tension Headache
❑	❑	Bell's Palsy
❑	❑	Poor Fine/Gross Motor Skills
❑	❑	Epilepsy
❑	❑	Inflammation
❑	❑	Trigeminal Neuralgia
❑	❑	Ear Ringing/Tinnitus
❑	❑	Auditory Processing
❑	❑	Toe Walking
❑	❑	Vertigo/Dizziness
❑	❑	Sensory Integration
❑	❑	Stroke
❑	❑	Memory Issues
❑	❑	Fainting
❑	❑	Other _______________

ENDOCRINE ❑ N/A

Present	Past	
❑	❑	Hyper/Hypo Thyroid
❑	❑	Diabetes Type 1 or 2
❑	❑	Hair Loss
❑	❑	Menopause
❑	❑	Menstrual Problems
❑	❑	Hot Flashes
❑	❑	Endometriosis
❑	❑	Polycystic Ovarian Syndrome
❑	❑	Other _______________

PSYCHIATRIC ❑ N/A

Present	Past	
❑	❑	Mood Swings
❑	❑	Depression
❑	❑	Anxiety
❑	❑	Bipolar Disorder
❑	❑	OCD
❑	❑	Seasonal Affective Disorder
❑	❑	Substance Abuse
❑	❑	Eating Disorder
❑	❑	Other _______________

CONSTITUTIONAL ❑ N/A

Present	Past	
❑	❑	Weight Loss/Gain
❑	❑	Energy Level Low
❑	❑	Energy Level High
❑	❑	Difficulty Sleeping
❑	❑	Chronic Fatigue
❑	❑	General Malaise
❑	❑	Compulsive Behaviour
❑	❑	Behaviour Issues
❑	❑	Learning Disabilities
❑	❑	Speech Delays
❑	❑	RLS
❑	❑	Pregnancy/Fertility
❑	❑	Obesity
❑	❑	Other _______________