Vibrant Sol Chiropractic
9107 SE 29th St., Ste B., Midwest City, OK, 73130
405-739-0594

COMPREHENSIVE PEDIATRIC MEDICAL HISTORY

Confidential Medical Record – Unauthorized Use Strictly Prohibited

Patient Name		Date
Street Address	City/State	Zip Code
Guardian Home Phone ( )	Guardian Work Phone ( )	Guardian Cell Phone/Pager ( )
Email Address	Date of Birth	Current Age:
Social Security #	Method of Payment	

Mothers Name:	Father's Name:
Legal Guardian:	Other:

Patient's Personal Physician:	Type of Doctor:
Doctors Phone #:	Date of Child's Last Exam: Diagnosis:

Insurance Information:

Name or Insurance Company	Billing Address	Policy # and Subscriber

Referred by:

Patient Name:	Physician Name	Other

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Ross Solis DC, DACNB to administer chiropractic care as he deems necessary to my son/daughter, _____, dated at Vibrant Sol Chiropractic this _____ day of _____, 20____.

Signature: **Witnessed**:

IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone	Work Phone	Cell Phone

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PERSONAL HISTORY Completed by:_____

Height Ft. Inches	Weight Lbs.	Percentile Rank

Current School Grade:_____ Private School Public School N/A Other

Academic Performance: Not in School Remedial/Special Ed Below Average Average Above Average

Number of weeks gestation: Pre-term # of weeks_____ Full term (38-40 wks) Post term - # of weeks_____

Birth by: NSVD VD-induced C-Section Complications: No Yes
Explain_____

Birth Weight:_____lbs_____ oz. Apgar Score:_____/_____

Was child breast fed? Yes # of months_____ No Formula/Type:_____

At what age was child introduced to solid foods?_____ Any negative reactions? No Yes_____

Estimate courses of antibiotics during 1st year of life:_____ Total since birth:_____

How many bowel movements a day on average? Frequently constipated 1 2 3 Greater than 3

Does child have undigested food in stool? No Occasionally Often Always

Immunizations: None Some _ _____ All immunization up-to-date for age

Did child have reaction(s) to any immunizations? No Yes Explain:_____

At what age did child first sit-up? _____ Precocious Average Delayed Other_____
point to objects? _____ Precocious Average Delayed
first crawl? _____ Precocious Average Delayed Other _____
first walk? _____ Precocious Average Delayed Other _____

Does child seem to avert eye contact? No Rarely Yes
Does child avoid or fear strangers? No Rarely Yes

Motor skills are considered? Precocious Average Delayed Other _____
Speech is considered? Precocious Average Delayed Other_____

How many hours/night does child sleep on average? <4-5 6–7 7–8 9–10 10+ Is sleep disturbed? No Yes

Rate the quality of sleep? 1-------2-------3-----4-------5-------6-------7-------8-------9-------10
(Poor) (Average) (Excellent)

Does child have night terrors? Never Rarely Sometimes Often
Does child have dark circles under eyes? No Occasionally Often

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Does child have any unexplained rashes or itching, especially in the ears, groin or belly button? No Sometimes Often
Does child have a chronic whitish or brown coating on tongue that cannot be brushed off? No Yes
Does child have dry skin or eczema? No Sometimes Yes

Does child seem to have excessive thirst? No Sometimes Yes

Does child seem "addicted" to sugars, sweets and carbohydrates? No Sometimes Often

Does child get headaches after eating sugar, bread, pasts, fruit, or cereal? Never Sometimes Often

Has child's language skills seem to have regressed? No Possibly Yes

MATERNAL HISTORY

Age of mother at pregnancy?_____ # Pregnancy: First Second Third Fourth Other _____

Did mother have any medical problems PRIOR to pregnancy?_____

Did mother smoke during pregnancy? No Yes # per day_____

Did mother drink alcohol during pregnancy? Never Yes Type: Wine Beer Liquor # drink/wk _____

Maternal complications during pregnancy? None High blood pressure Edema Diabetes Pre-eclampsia Eclampsia

Did mother take any medications or drugs during pregnancy? No Yes Type and amount:_____

_____

HAS CHILD (not a family member) EVER BEEN DIAGNOSED WITH

ADD or ADHD Never Past Yes:_____
Allergies/Hayfever Never Past Yes:_____
Asperger's syndrome (AS) Never Past Yes:_____
Asthma Never Past Yes:_____
Anemia Never Past Yes:_____
Autism Never Past Yes:_____
Bladder/Urine Infection (UTI) Never Past Yes:_____
Blood Pressure Problems Never Past Yes:_____
Bronchitis/Pneumonia Never Past Yes:_____
Colitis/Crohn's Disease Never Past Yes:_____
Croup Never Past Yes:_____
Cystic Fibrosis Never Past Yes:_____
Developmental Delay Never Past Yes:_____
Diabetes Type I (Juvenile Diabetes) Never Past Yes:_____
Dysentery/Food Poisoning Never Past Yes:_____
Dyslexia Never Past Yes:_____
Ear Infection (Otitis Media) Never Past Yes:_____
Easy Bruising Never Past Yes:_____
Eating Disorder Never Past Yes:_____

Eczema/Psoriasis – Skin Problems Never Past Yes:_____
Enlarged Heart Never Past Yes:_____
Epilepsy (Seizures) Never Past Yes:_____
Gastric Reflux or Ulcers Never Past Yes:_____
Goiter Never Past Yes:_____
Heart Murmur/Arrhythmia Never Past Yes:_____
Hemochromatosis (Iron Overload) Never Past
Yes:_____
Hepatitis/Jaundice Never Past Yes Hep A Hep B Hep C

Hives Never Past Yes:_____
Hperthryroidism Never Past Yes:_____
Hypothyroidism Never Past Yes:_____
Irritable Bowel (IBS) Never Past Yes:_____
Juvenile Rheumatoid Arthritis Never Past Yes:_____
Kidney Infection Never Past Yes:_____
Kidney Stones Never Past Yes:_____
Learning Disorder Never Past Yes:_____
Lyme Disease Never Past Yes:_____
Meningitis Never Past Yes:_____
Mental Retardation Never Past Yes:_____
Migraine Headaches Never Past Yes:_____
Mononucleuosis Never Past Yes:_____
Multiple Sclerosis (MS) Never Past Yes:_____
Obsessive Compulsive Disorder (OCD) Never Past Yes:_____
Pervasive developmental disorder Never Past Yes:_____
Pharyntgitis Never Past Yes:_____
Sinusitis Never Past Yes:_____
Speech Delay Never Past Yes:_____
Strep Throat Never Past Yes:_____
Syphilis/Chlamydia/STD Never Past Yes:_____
Tourette's Never Past Yes:_____
Yeast Infections Never Past Yes:_____
Other_____
Other_____

ALLERGIES:

Is child SENSITIVE/INTOLERANT/ALLERGIC to any of the following foods?

Milk/Dairy Wheat/Gluten Peanuts Soy Eggs Corn Yeast Chocolate Citrus Fish/Shellfish Strawberries
Other:_____

Do you live with any pets? No Yes Describe_____

Please list any allergies that your child has been diagnosed with or that you suspect._____
_____

Does anyone in the home smoke? Never No Yes Type: Cigarettes Cigars Pipes Other_____ Number/day:_____

MEDICATIONS: Is child currently taking (or recently discontinued) any PRESCRIBED medications?
Please List _____

OPERATIONS AND HOSPITALIZATIONS: No Yes Yr/Description_____

DEVICES: Please circle any of the following that the child utilizes:

Ear Tubes, Eyeglasses, Contact Lenses, Dental Braces, Back Brace, Knee Brace, Neck Brace, Implants, and/or Shunt.

How is child's dental health? Excellent Good Fair Poor

Has child had EYE exam? No Yes Date Last Exam_____
Has child had HEARING exam? No Yes Date Last Exam_____

TESTS: Has child ever had an X-ray, CAT-Scan, MRI, Sonogram, PET-scan, EKG or Bone Scan (circle which test) of:
No Yes Yr/Test/Result_____

FAMILY HISTORY: Has any blood relative (NOT CHILD) ever had any of the following?

ADD/AD(H)D No Yes Relation_____
Arthritis No Yes Relation_____
Asperger's Symdrome (AS) No Yes Relation_____
Asthma No Yes Relation_____
Autism No Yes Relation_____
Bleeding Disorder No Yes Relation_____
Bipolar Disorder No Yes Relation_____
Cancer No Yes Relation_____
Developmental Delay No Yes Relation_____
Diabetes Type I / II No Yes Relation_____
Emphysema No Yes Relation_____
Hepatitis B or C No Yes Relation_____
Hypothyroidism No Yes Relation_____
Learning Disability No Yes Relation_____
Mental Illness/Suicide No Yes Relation_____
Migraine Headaches No Yes Relation_____
Multiple Sclerosis No Yes Relation_____
Obsessive Compulsive Disorder (OCD) No Yes Relation_____
PDD No Yes Relation_____
Siezure Disorder/Epilepsy No Yes Relation_____
Speech Delay No Yes Relation_____
Tourette's Syndrome No Yes Relation_____

DIET AND NUTRITION: Does child consume any of the following?
Milk Dairy No Rarely Often Approx glasses/day_____
Difficulty digesting Milk/Dairy (Lactose Intolerant) No Not Aware Yes Wheat/Gluten containing grains/cereals No Rarely Often
Soda/Cola No Rarely Often Approx glasses/day_____ Type_____
Juices-Orange/Apple No Rarely Often Approx glasses/day_____
Water directly from Tap Never/Rarely Sometimes Mostly
Soy-Containing Foods No Occasionally Often – (Circle) Soy milk Tofu Soy Protein Times/Week:_____

How many meals plus snacks per day does child eat on average? 1 2 3 4 5 Graze

Does child eat fruits and vegetables? Frequently Rarely Almost Never

How many times/week, on average, does child eat Fish/Seafood? More than 3 Rarely 1 – 2X/Wk Almost Never

Which Fats/Oils does child consume?
Butter Olive Oil Coconut Oil Flax Oil Safflower Oil Sunflower Oil Peanut Oil Grape Seed Oil Macadmaia Oil
Mayonnaise Margarine Crisco Corn Oil Soybean Oil Canola Oil

Is Child in any special diet?
Dairy-Free Wheat/Gluten-Free Yeast-Free Feingold Low Carbohydrate High Protein No Special Diet
Other:_____

What diet type does child primarily consume?
High Carbohydrate – Bread, pasta, cereal, rice, potatoes, juices, sweets, etc High Protein – Meat, fish, fowl, eggs, nuts, etc.
Vegetarian – No meat at all
No Special Diet – Large variety of protein, vegetables, and carbohydrates

Please list the foods in child's "usual" (Please be specific):
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Other _____

Name the five foods consumed MOST frequently (Please be specific)
1. _____
2. _____
3. _____
4. _____
5. _____

List all vitamins, minerals, herbs, amino acids, and nutritional supplements (with dose) you are taking on a regular basis:
1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____

*Directions: Circle impression of the following using grading system "0" not at all to "10" very severe.

Psychological/Emotional

Seems angry at times	0	1	2	3	4	5	6	7	8	9	10
Seems depressed	0	1	2	3	4	5	6	7	8	9	10
Picks on other children	0	1	2	3	4	5	6	7	8	9	10

Disliked by other children 0 1 2 3 4 5 6 7 8 9 10

Has difficulty making friends 0 1 2 3 4 5 6 7 8 9 10

Shows poor self-esteem 0 1 2 3 4 5 6 7 8 9 10

Sleeps excessively 0 1 2 3 4 5 6 7 8 9 10

Violent behavior 0 1 2 3 4 5 6 7 8 9 10

Immature behavior 0 1 2 3 4 5 6 7 8 9 10

Physically hurts self or others 0 1 2 3 4 5 6 7 8 9 10

Score_____

Attention/Hyperactivity

Trouble staying seated for class work 0 1 2 3 4 5 6 7 8 9 10

Fidgets excessively in seat 0 1 2 3 4 5 6 7 8 9 10

Doesn't finish work 0 1 2 3 4 5 6 7 8 9 10

Easily distracted 0 1 2 3 4 5 6 7 8 9 10

Acts before thinking 0 1 2 3 4 5 6 7 8 9 10

Interrupts, often calls out 0 1 2 3 4 5 6 7 8 9 10

Requires assistance to accurately complete assignment 0 1 2 3 4 5 6 7 8 9 10

Excessively stares or appears "spaced out" 0 1 2 3 4 5 6 7 8 9 10

Academic

Disorganized 0 1 2 3 4 5 6 7 8 9 10

Loses things needed for tasks 0 1 2 3 4 5 6 7 8 9 10

Poor math/science skills 0 1 2 3 4 5 6 7 8 9 10

Poor language/vocabulary skills 0 1 2 3 4 5 6 7 8 9 10

Slow to begin/finish schoolwork 0 1 2 3 4 5 6 7 8 9 10

Poor memory 0 1 2 3 4 5 6 7 8 9 10

Forgetful about school assignments and tasks 0 1 2 3 4 5 6 7 8 9 10

Makes careless errors or mistakes 0 1 2 3 4 5 6 7 8 9 10

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Poor penmanship 0 1 2 3 4 5 6 7 8 9 10

Has trouble following teacher instructions/group direction 0 1 2 3 4 5 6 7 8 9 10

Score_____

MAIN REASON AND GOALS OF APPOINTMENT:

_____
_____
_____
_____
_____
_____

Please honestly rate your ability, resources, and desire to make the necessary lifestyle, medical, dietary, supplement, and nutrition commitments and modifications for your child in order to significantly impact the typical "natural" course of current disease or disorder.

Likely only minor changes Likely only moderate changes Likely I can make major changes I can do almost everything it may take

Do you freely choose and desire Complementary/Integrative/Alternative treatment(s) for your child's medical condition(s) and understand that along with the significant benefits that can often be achieved there may always be, as with all treatments, some inherent risk? YES NO

To the best of my knowledge all of the above information is true and accurate.

Parent/Guardian Signature:_____
For Patient:_____ Date:_____