

# WINCHESTER HOSPITAL CHIROPRACTIC CENTER



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Dr. Heidi Henrickson  
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Dr. Gary Kane



*We are excited you are here. We offer a unique service to individuals and families. We will make every effort to make your experience supportive, informative and healing.*

Child's Name \_\_\_\_\_ Parent's Names \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M / F Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Name of child's pediatrician and location \_\_\_\_\_ Can we contact them if needed \_\_\_\_\_

Who told you about our office \_\_\_\_\_ Reason for today's visit \_\_\_\_\_

## **BIRTH MOTHER'S PREGNANCY**

Did the mother have any injuries during the pregnancy (accidents, falls, etc.) \_\_\_\_\_

Any treatment required during the pregnancy (chiro., PT, massage, etc.) \_\_\_\_\_

Any health problems during the pregnancy (diabetes, pre-eclampsia, bed rest, etc.) \_\_\_\_\_

Any medications or drugs taken during the pregnancy \_\_\_\_\_ Did the mother smoke \_\_\_\_\_

## **LABOR AND DELIVERY**

Problems during labor and delivery \_\_\_\_\_

Type of birth: Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_ Forceps \_\_\_\_\_ Vacuum Extraction \_\_\_\_\_ Home Birth \_\_\_\_\_

Name of Hospital/Delivery Center \_\_\_\_\_ Was a Midwife or Doula used \_\_\_\_\_

Length of Labor \_\_\_\_\_ Length of Delivery (pushing) \_\_\_\_\_ Did the mother have an epidural \_\_\_\_\_

Baby's birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ APGAR Scores \_\_\_\_\_ Length of Hospital stay \_\_\_\_\_

Problems with the baby after delivery \_\_\_\_\_

## **CHILD'S HEALTH HISTORY**

Health problems with the child now or in the past \_\_\_\_\_

Accidents or injuries to the child (falls, car, sports, broken bones) \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1<sup>st</sup> year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child?  No  Yes

Was the child breast fed \_\_\_\_\_ If so, for how long \_\_\_\_\_ Was the child bottle fed \_\_\_\_\_ For how long \_\_\_\_\_

Current milk: Breast \_\_\_\_\_ Formula/Type \_\_\_\_\_ Cow's milk-what % \_\_\_\_\_ Soy milk \_\_\_\_\_ Rice milk \_\_\_\_\_

Frequency of eating \_\_\_\_\_ Current food/snacks \_\_\_\_\_

Any known food or environmental allergies/intolerances \_\_\_\_\_

Current medications \_\_\_\_\_ Current behavior \_\_\_\_\_

Number of hours of sleep per night \_\_\_\_\_ Quality of sleep: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**PLEASE COMPLETE THE OTHER SIDE OF THIS FORM**

**GENERAL SYMPTOMS** Check symptoms the child currently has or has had in the past year

**GENERAL**

- ADD/ADHD
- Allergies
- Autism/Asperger's
- Anemia
- Bed Wetting
- Behavioral Problems
- Bladder Infection
- Broken Bones
- Cancer/Tumors
- Depression
- Diabetes
- Difficulty Sleeping
- Dizziness
- Dyslexia
- Epilepsy
- Fainting
- Growing Pains
- Heart Problems
- Hodgkin's Lymphoma
- Hyperactivity
- Juvenile Arthritis
- Nightmares
- Night Sweats
- Paralysis
- PDD
- Seizures
- Speech Problems
- Stroke

**EYE, EAR, NOSE & THROAT**

- Pink Eye
- Vision Problems
- Dizziness
- "Crossed" Eyes
- Ringing in Ears
- Hearing Loss
- Earache
- Ear Infections
- Nose Bleeds
- Sinus Problems
- Bad Breath
- Colds-Flu
- Frequent Runny Nose

**RESPIRATORY**

- Asthma
- Bronchitis
- Pneumonia
- Mononucleosis
- Shortness of Breath
- Cough/Wheeze

**GASTRO-INTESTINAL**

- Poor Appetite
- Excessive Appetite
- Bloating/Gas
- Indigestion
- Nausea
- Reflux
- Constipation
- Diarrhea
- Colitis/IBS
- Hernia

**HEAD, NECK and SPINE**

- Headaches
- Neck Pain
- Neck Stiffness
- Torticollis
- Midback Pain
- Low back Pain
- Back Spasms
- Scoliosis
- Muscle/joint pain

**ARMS and HANDS**

- Shoulder Pain
- Broken Collar Bone
- Erb's Palsy
- Elbow Pain
- Dislocated Elbow
- "Little League Elbow"
- Wrist or Hand Pain
- Numbness or Tingling in arms

**HIPS, LEGS and FEET**

- Buttocks Pain
- Hip Pain
- Congenital Hip Dysplasia
- Knee Pain
- Ankle or Foot Pain
- Toes turn in or out
- Bow Legs or Knock Knees
- Walks on Toes
- Flat Feet
- Limp

**SKIN**

- Eczema
- Psoriasis
- Hives
- Rash
- Bumps on back of arms or legs
- Dark circles under eyes or puffiness

**CHILDHOOD ILLNESSES**

- Chicken Pox
- Colic
- Croup
- Diphtheria
- Measles
- Mumps
- RSV
- Rubella
- Tetanus
- Whooping Cough

**OTHER:**

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*Authorization for care of a minor: I hereby authorize Winchester Hospital Chiropractic Center and its doctors to administer care as they deem necessary to my son/daughter/ward. I accept responsibility for payment for services rendered.*

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Today's Date \_\_\_\_\_

Witnessed \_\_\_\_\_ Today's Date \_\_\_\_\_