bodywork therapy kinetikos

Pediatric Health History Form

Child's Name: _____ Age: _____ Birthdate: _____
Parents' Names: _____
Address: _____ Phones: cell _____ other _____
City/State/Zip: _____ Email: _____

Health History

Has your child ever experienced the following:

- ❑ Anxiety
- ❑ Asthma
- ❑ Balance issues
- ❑ Braces
- ❑ Broken bones
- ❑ Chemical or heavy metal exposure
- ❑ Cognitive developmental delays
- ❑ Constipation
  - ☐ chronic ☐ occasional
- ❑ Diarrhea
  - ☐ chronic ☐ occasional
- ❑ Difficulty concentrating and/or short attention span
- ❑ Dislocated bones
- ❑ Dizziness, fainting, and/or balance issues
- ❑ Ear infections
- ❑ Eczema
- ❑ Epilepsy
- ❑ Excessive spitting up
- ❑ Eye motor issues
- ❑ Fetal alcohol or drug exposure
- ❑ Finger sucking
- ❑ Follow a specific diet
- ❑ Food allergies and/or sensitivities
- ❑ Gastrointestinal issues
- ❑ Head trauma, concussion, and/or external head bump
- ❑ Headaches
  - ☐ chronic ☐ occasional
- ❑ Hernia
- ❑ Hospitalization (other than birth)
- ❑ Infection (other than ear or sinus)
- ❑ Inhalant allergies
- ❑ Jaw pain, tension, and/or clicking
- ❑ Joint or limb pain
- ❑ Kidney issues
- ❑ Lip or tongue tie revision
- ❑ Major fall, injury, or physical trauma
- ❑ Major life change (i.e., move, divorce, change of peer group)
- ❑ Orthodontics
- ❑ Physical developmental delays
- ❑ Rash or other skin condition
- ❑ Seasonal allergies
- ❑ Sinus infection or other sinus issues
- ❑ Sleep disturbances (i.e., difficulty staying asleep, night terrors, insomnia, etc)
- ❑ Stomachaches
- ❑ Surgery
- ❑ Tinnitus
- ❑ Urinary tract infection
- ❑ Verbal, physical, or sexual abuse
- ❑ Vision disturbances

Please elaborate on any boxes checked above and list any additional symptoms or major illnesses not mentioned above:

_____
_____
_____
_____
_____
_____

Reason for today's visit: _____

Birthing Experience:

Child was born: ☐ in hospital ☐ at birth center ☐ at home
Delivery was: ☐ without drugs ☐ with Pitocin ☐ with epidural ☐ with anesthesia for Cesarean
Delivery was: ☐ vaginal ☐ Cesarean
Delivery was how long: _____ If vaginal delivery, mother pushed for how long: _____
Please describe any complications: _____
_____

Infant feeding (please complete for any age of child): ☐ breastfed ☐ formula-fed ☐ both
Please elaborate on any infant feeding issues:
_____
_____

Does your child:

Take any medication? ☐ Yes ☐ No
If yes, which one(s): _____
Take any supplements? ☐ Yes ☐ No
If yes, which one(s): _____
Receive vaccinations? ☐ Yes ☐ No
If yes, do you follow ☐ regular vaccination schedule or ☐ alternate vaccination schedule?

Has your child taken antibiotics? ☐ Yes ☐ No If yes, how many times: _____

Daily Living Considerations:

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Split custody ☐ Other legal guardian
Does this child have siblings? ☐ Yes ☐ No

Primary care physician _____ Other health care provider _____
(e.g., medical specialist, chiropractor, acupuncturist)
Is it okay to contact your other providers? (we will always notify you if it is necessary to do so)? ☐ Yes ☐ No
In case of an emergency, contact: Name _____ Telephone _____
If you were referred to our office, who referred you? _____

The information above is complete and accurate to the best of my knowledge. I understand that bodywork therapy does not take the place of physicians' services. The bodywork and information that I receive during a bodywork session is for the purposes of improving my general health. I will keep the therapist informed of any changes in my health as they occur. My signature below indicates that I understand and agree to the above conditions.

Signature of Guardian:_____Date:_____