Riordan Clinic
Pediatric Chiropractic History

Child's Name_____ Date of Birth _____

Parent's Names _____ Date of 1st Appointment _____

Prenatal and Perinatal Factors

If you circle "YES" to any of the below, please provide a short explanation in the space provided.

1. How was your health during pregnancy?
   _____
   _____

1. How old were you when your child was born? _____
2. Please circle the following items used during the pregnancy; indicate frequency.

   Beer or wine

   Hard liquor

   Soda pop

   Cigarettes

   Medications (please list)

   Other drugs

   Vitamins (please list)

3. Did you have dental work during pregnancy? YES NO
4. Did you have the Rhogam injection? YES NO
5. Did you have toxemia or eclampsia? YES NO
6. What was the approximate duration of labor? _____ Hours
7. Was the baby premature, or overdue? YES NO
8. Were there indications of fetal distress during or after the delivery? YES NO

9. Was the delivery (please circle): Normal Breech Caesarian Forceps Induced

10. What was the child's approximate weight? _____

11. Were there any complications following the birth? YES NO

12. Is there a family history of birth disorders or congenital diseases? YES NO

Postnatal Period and Infancy

If you circle "YES" to any of the below, please provide a short explanation in the space provided.

1. Were there early infancy feeding problems? YES NO

2. Was the child colicky (stomachache or bowel spasms)? YES NO

3. Were there early infancy sleep pattern difficulties? YES NO

4. Did the child experience any health problems during infancy? YES NO

5. Did the child have any vaccination problems? YES NO

6. Was the child an easy baby? (For example, rarely cried or on a good schedule)
   Very easy Easy Average Difficult Very Difficult

7. How did the baby behave with other people?
   More sociable than average Average sociability More unsociable than average

8. When (s)he wanted something, how insistent was (s)he?
   Very Pretty Average Not very Not at all

9. Were/Are you aware of any developmental delays?

10. Did the child have ear infections (or other infections) requiring frequent antibiotics?

11. Was the child on any regular meds or vitamins?

Medical History

1. How would you describe his/her health?

2. How is his/her hearing?

3. How is his/her vision?

4. How is his/her gross motor coordination?

5. How is his/her fine motor coordination?

6. How is his/her speech articulation?

7. Has (s)he had any chronic health problems (e.g. asthma, diabetes, heart condition)?
    a. If so, at what age did the chronic illness begin:_____

8. Has your child had: (please circle)

a. Mumps	Chicken Pox
b. Measles	Whooping cough
c. Scarlet fever	Pneumonia
d. Encephalitis	Otitis media (ear infection)
e. Lead poisoning	Seizures

9. Has the child had any falls or accidents? YES NO

10. What surgeries have your child had?

11. Does the child have any problems sleeping?
    a. None Difficulty falling asleep Frequent awakening Early morning awakening

12. Is the child a restless sleeper? YES NO

13. Does the child have any of the following digestive issues?
    a. Stomach ache Diarrhea Constipation Gas/bloating Belching