TURNING POINT CHIROPRACTIC

PEDIATRIC HISTORY FORM

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Birthdate: _____-_____-_____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: _____-_____-_____

Father's Phone: Home _____ Work _____ Mobile _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

Who is responsible for this bill? _____

○ Father's Social Security #: _____-_____-_____ ○ Mother's Social Security #: _____-_____-_____

○ Father's Driver's License #: _____ ○ Mother's Driver's License #: _____

○ Other *(please explain)*: _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? _____

5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes **If yes,** please explain:

_____

_____

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10. Has your child ever sustained an injury in an auto accident? ○ No ○ Yes **If yes,** please explain:

_____

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

○ Headaches	○ Orthopedic Problems	○ Digestive Disorders	○ Behavioral Problems
○ Dizziness	○ Neck Problems	○ Poor Appetite	○ ADD/ADHD
○ Fainting	○ Arm Problems	○ Stomach Aches	○ Ruptures/Hernia
○ Seizures/Convulsions	○ Leg Problems	○ Reflux	○ Muscle Pain
○ Heart Trouble	○ Joint Problems	○ Constipation	○ Growing Pains
○ Chronic Earaches	○ Backaches	○ Diarrhea	○ Asthma
○ Sinus Trouble	○ Poor Posture	○ Hypertension	○ Walking Trouble
○ Scoliosis	○ Anemia	○ Colds/Flu	○ Sleeping Problems
○ Bed Wetting	○ Colic	○ Broken Bones	○ Fall off swing
○ Fall in baby walker	○ Fall from bed or couch	○ Fall from crib	○ Fall down stairs
○ Fall off bicycle	○ Fall from high chair	○ Fall off slide	
○ Fall from changing table	○ Fall off monkey bars	○ Fall off skateboard/skates	

○ Allergies to

_____

○ Other:

_____

I understand that I am directly and fully responsible to [Insert Practice Name] for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

TURNING POINT CHIROPRACTIC

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____ - _____ - _____

Parent or Legal Guardian's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

TURNING POINT CHIROPRACTIC

Pediatric Examination Form

Number: _____

PATIENT NAME: _____ **DATE:** _____

Vitals: Length: _____ Weight: _____ HR: _____ Temperature: _____ Age: _____

KINESIOPATHOLOGY

CERVICAL ROM WNL ☐

C EXT_____

C FLEX_____

C RROT_____

C LROT_____

C RLF_____

C LLF_____

THORACIC/LUMBAR ROM WNL ☐

TL EXT_____

TL FLEX_____

TL RROT_____

TL LROT_____

TL RLF_____

TL LLF_____

MYOPATHOLOGY

Spasm: _____

_____

FONTANELS: ANT: P/A POST: P/A

SHAPE OF CRANIUM: WNL ☐

_____

_____

_____

Facial Observation: WNL ☐

_____

_____

SLR: N L+/R+ **Knee Chest: N** L+/R+

Heel Buttocks: N L+/R+ **Fig4 N** L+/R+

POSTURE FOR LEGS

HIPS: N Asymmetrical/Rotated

Ortolini: N L+/R+ **Barlow: N** L+/R+ for click

KNEES: N Varus / Valgus L/R

FEET & ANKLES: **N** pronated / supine

Calcaneous: N valgus / varus L/R

Talipes equinovarus: **N** L/R rigid / functional

POSTURAL EVALUATION:

L	SPH	R
	C0	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	SAC	
	SI	
	CX	

TURNING POINT CHIROPRACTIC

MOVEMENT OF ARMS AND LEGS

SYMMETRICAL: Y/N _____

TONE: GOOD / ELEVATED / DIMINISHED _____

NEUROPATHOPHYSIOLOGY

Cranial Nerves: N L/R or I,II,III,IV,V,VI,VII,VIII,IX,X,XI,XII

Accommodation: Direct / Indirect

HISTOPATHOLOGY

+ JUMP SIGN: _____ Lymph Nodes: **N** _____

Inflammation_____ Tissue congestion Y/N_____

Bogginess/Dark circles under eyes: Y/N_____

Bruising Y/N _____

SPECIAL TESTS

Head circumference full: _____ Chest circumference_____

Nasopalpation (blink) P/A Palmer Grasp: P/A Plantar grasp: P/A

Rooting: P/A Sucking: P/A Gag: P/A Moro: P/A Inversion: N /_____

Rotation: P/A Placing: P/A Steppage: P/A Fencer: P/A Galant: P/A

Leg Check: D+ / D- L/R Cervical Syndrome: Y/N Bilateral - R/L

Glut Squeeze: N L/R Stair Step: N or Absent High Occiput: Y/N L/R

REFLEXES		
Bicep	N	L/R
Brachial	N	L/R
Tricep	N	L/R
Patella	N	L/R
Achilles	N	L/R
Babinski	N	L/R

KEY

N = Normal
P = Present
A= Absent
Y/N = Yes/No
L/R = Left/Right
SAC = Sacrum
SI = Sacroiliac Joint

EXTREMITIES:_____
_____
_____

GENERAL OVERVIEW

KINESIOPATHOLOGY: *mild, mod, severe, extreme*
MYOPATHOLOGY: *mild, mod, severe, extreme*
HISTOPATHOLOGY: *mild, mod, severe, extreme*
NEUROPATHOPHYSIOLOGY: *mild, mod, severe, extreme*

CASE SUMMARY _____
_____

TURNING POINT CHIROPRACTIC

Reflex	Expected Response	Normal	Abnormal
Rooting (0-4m)	Infant turns head towards side of cheek stroked		
Suckling Reflex (0-4m)	Should feel and enthusiastic suckling on finger		
Palmar/ Plantar Reflex	Fingers/ toes should wrap around		
Babinski	Toes should curl		
Tonic Neck Reflex (Fencer)	Turn head to one side, ipsilat. Extremeties should extend, contralat. Should flex		
Light Reflex	Eyes close with light		
Moro Reflex	Arms should extend overhead when imitating the act of falling		
Parachute Reflex (6m-1yr)	Infant should extend arms and legs out to brace for "landing"		

Milestone	Age	Met	Not Met	Delayed/ Early
Fists clench	1 month			
Smiles, Coos, Hands open	2 months			
Head Control	3 months			
Push up on Hands	4 months			
Rolls stomach to back; puts weights on legs	5 months			
Sits without support; rolls both directions; does "push ups"; tries to move forward (rocking)	7 months			
Sits alone	8 months			
Pulls up to stand; crawling	10 months			
Cruising	11 months			
Walks with support	12 months			