



Phoenix
 Network Care
 Create Life Anew.

PERSONAL HISTORY QUESTIONNAIRE FOR INFANTS AND CHILDREN

Date: _____

Name: _____ ~Male/Female
 Address: _____ City: _____ Postal Code: _____
 Phone: _____ Date of Birth: _____ Age: _____
 Name of Parent/Guardian: _____ Marital Status of Parent(s): _____
 Number of Children in home: _____ Names and Ages of other Children in family: _____

How did you discover our office? _____

What is the purpose and motivation for seeking care and what do you hope to receive here? _____

If health concerns are a motivation, please describe: _____

How does this affect the rest of the family (siblings, parents), playing, schooling? _____

Has your child's spine ever been examined? Yes No

If yes, when, and by whom? _____

Last visit to Doctor/Pediatrician, when and reason for visit: _____

Your child will receive a spinal examination following the completion of this history. Even throughout a young life, stressful events (which may be physical, chemical, mental and/or emotional) occur that can overwhelm us. These stresses can cause tension and damage to the brain, spinal cord and spinal bones, which may **interfere with the function of the nervous system, thereby decreasing the health and well being of the individual**. The following questions give us more information about some of the stresses that your child may have experienced.

PREGNANCY

Did the mother:

Yes	No	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Smoke or drink alcohol? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have a nutritious diet? _____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise through her pregnancy? _____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any falls or injuries? _____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any physical stresses (i.e. falls, car accidents)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any mental/emotional stresses (i.e. relationship, financial)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any chemical stresses (i.e. prescribed or recreational drugs)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Become outwardly ill before her pregnancy? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have any ultrasounds? _____

BIRTH PROCESS

Yes No

- Hospital birth home birth birthing center
- Was the delivery long? _____
- Was the delivery difficult? _____
- Forceps / suction / vacuum extraction (circle)? _____
- Caesarian ("c" section)? Emergency or planned (circle)? _____
- Breech / cephalic? _____
- Cord around neck? _____
- Silver nitrate in eyes following birth? _____
- Incubated or isolated after birth? _____
- Mother given drugs at delivery (Ptoicin, epidural, etc.)? _____
- Conscious Semi-conscious Unconscious _____
- Was labor induced? _____
- Complications during delivery? _____

GROWTH AND DEVELOPMENT

Yes	No	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Breast-fed? _____
<input type="checkbox"/>	<input type="checkbox"/>	Bottle-fed? _____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery (i.e. hernia, tonsils, etc.)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalized? _____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs (i.e. antibiotics, penicillin, etc.)? _____
Number of <u>antibiotics</u> this child has taken: during the past 6 months _____, total during lifetime _____		
Number of <u>other prescription medications</u> : during the past 6 months _____, total during lifetime _____		
Please list: _____		
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse? _____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Mental / Emotional Stress (i.e. divorce, move, change schools) _____
Vaccination history:		
<input type="checkbox"/>	<input type="checkbox"/>	DPT _____
<input type="checkbox"/>	<input type="checkbox"/>	MMR _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Flu _____

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (i.e. a bed, changing table, grocery cart, stairs, etc.). Did this happen? Yes No
 If yes, please explain _____

Any other traumas (physical, mental, emotional and/or chemical that would help us better understand this situation?)

Is this child involved in any high impact sports (i.e. football, hockey, cheerleading, gymnastics, soccer)? Yes No

Is there anything else you wish to share? _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO PARTICIPATE AND ASK QUESTIONS.

Consent for patients under the age of 16

I _____
Parent/Guardian hereby authorize Dr. Piazza to perform a physical examination and administer care to my son/daughter as he deems necessary. I understand that all information will remain confidential.

Parent / Guardian Signature _____ Date _____