

COMPREHENSIVE PEDIATRIC MEDICAL HISTORY

Confidential Medical Record – Unauthorized Use Strictly Prohibited

Patient Name		Date	
Street Address		City/State	Zip Code
Guardian Home Phone ()	Guardian Work Phone ()	Guardian Cell Phone/Pager ()	
Email Address	Date of Birth	Current Age:	Years Months
Social Security #	Method of Payment		

Mothers Name:	Father's Name:
Legal Guardian:	Other:

Patient's Personal Physician:	Type of Doctor:
Doctors Phone #:	Date of Child's Last Exam: Diagnosis:

Insurance Information:

Name or Insurance Company	Billing Address	Policy # and Subscriber
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Referred by:

<input type="checkbox"/> Patient Name:	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Other
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I understand and agree that health insurance policies are an arrangement between and insurance carrier and myself. The practitioners at Azzolino Chiropractic Neurology Group do not participate in any HMO/PPO organizations. I understand that the Doctor's Office will prepare any necessary forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of services.

Guardian Signature _____ Date: _____

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Sergio F. Azzolino, DC, DACNB and whomever he may so designate as his assistant, to administer chiropractic care as he deems necessary to my son/daughter, _____, dated at San Francisco this _____ day of _____, 20____.	
Signature:	Witnessed:

IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone	Work Phone	Cell Phone

PERSONAL HISTORY Completed by: _____

Height	Ft.	Inches	Weight	Lbs.	Percentile Rank
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Current School Grade: _____ Private School Public School N/A Other

Academic Performance: Not in School Remedial/Special Ed Below Average Average Above Average

Number of weeks gestation: Pre-term # of weeks _____ Full term (38-40 wks) Post term - # of weeks _____

Birth by: NSVD VD-induced C-Section Complications: No Yes Explain _____

Birth Weight: _____ lbs _____ oz. Apgar Score: _____ / _____

Was child breast fed? Yes # of months _____ No Formular/Type: _____

At what age was child introduced to solid foods? _____ Any negative reactions? No Yes _____

Estimate courses of antibiotics during 1st year of life: _____ Total since birth: _____

How many bowel movements a day on average? Frequently constipated 1 2 3 Greater than 3

Does child have undigested food in stool? No Occasionally Often Always

Immunizations: None Some _____ All immunization up-to-date for age

Did child have reaction(s) to any immunizations? No Yes Explain: _____

At what age did child first sit-up? _____ Precocious Average Delayed Other _____
 point to objects? _____ Precocious Average Delayed
 first crawl? _____ Precocious Average Delayed Other _____
 first walk? _____ Precocious Average Delayed Other _____

Does child seem to avert eye contact? No Rarely Yes

Does child avoid or fear strangers? No Rarely Yes

Motor skills are considered? Precocious Average Delayed Other _____

Speech is considered? Precocious Average Delayed Other _____

How many hours/night does child sleep on average? 4-5 6-7 7-8 9-10 10+ Is sleep disturbed? No Yes

Rate the quality of sleep? 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 (Poor) (Average) (Excellent)

Does child have night terrors? Never Rarely Sometimes Often

Does child have dark circles under eyes? No Occasionally Often

Does child have any unexplained rashes or itching, especially in the ears, groin or belly button? No Sometimes Often

Does child have a chronic whitish or brown coating on tongue that cannot be brushed off? No Yes

Does child have dry skin or eczema? No Sometimes Yes

Does child seem to have excessive thirst? No Sometimes Yes

Does child seem “addicted” to sugars, sweets and carbohydrates? No Sometimes Often

Does child get headaches after eating sugar, bread, pasts, fruit, or cereal? Never Sometimes Often

Has child’s language skills seem to have regressed? No Possibly Yes

MATERNAL HISTORY

Age of mother at pregnancy? _____ # Pregnancy: First Second Third Fourth Other _____

Did mother have any medical problems PRIOR to pregnancy? _____

Did mother smoke during pregnancy? No Yes # per day _____

Did mother drink alcohol during pregnancy? Never Yes Type: Wine Beer Liquor # drink/wk _____

Maternal complications during pregnancy? None High blood pressure Edema Diabetes Pre-eclampsia Eclampsia

Did mother take any medications or drugs during pregnancy? No Yes Type and amount: _____

HAS CHILD (not a family member) EVER BEEN DIAGNOSED WITH

- ADD or ADHD Never Past Yes: _____
- Allergies/Hayfever Never Past Yes: _____
- Asperger’s syndrome (AS) Never Past Yes: _____
- Asthma Never Past Yes: _____
- Anemia Never Past Yes: _____
- Autism Never Past Yes: _____
- Bladder/Urine Infection (UTI) Never Past Yes: _____
- Blood Pressure Problems Never Past Yes: _____
- Bronchitis/Pneumonia Never Past Yes: _____
- Colitis/Crohn’s Disease Never Past Yes: _____
- Croup Never Past Yes: _____
- Cystic Fibrosis Never Past Yes: _____
- Developmental Delay Never Past Yes: _____
- Diabetes Type I (Juvenile Diabetes) Never Past Yes: _____
- Dysentery/Food Poisoning Never Past Yes: _____
- Dyslexia Never Past Yes: _____
- Ear Infection (Otitis Media) Never Past Yes: _____
- Easy Bruising Never Past Yes: _____
- Eating Disorder Never Past Yes: _____
- Eczema/Psoriasis – Skin Problems Never Past Yes: _____
- Enlarged Heart Never Past Yes: _____
- Epilepsy (Seizures) Never Past Yes: _____
- Gastric Reflux or Ulcers Never Past Yes: _____
- Goiter Never Past Yes: _____
- Heart Murmur/Arrhythmia Never Past Yes: _____
- Hemochromatosis (Iron Overload) Never Past Yes: _____
- Hepatitis/Jaundice Never Past Yes Hep A Hep B Hep C

Hives	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Hperthyroidism	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Hypothyroidism	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Irritable Bowel (IBS)	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Juvenile Rheumatoid Arthritis	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Kidney Infection	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Kidney Stones	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Learning Disorder	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Lyme Disease	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Meningitis	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Mental Retardation	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Migraine Headaches	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Mononucleuosis	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Multiple Sclerosis (MS)	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Pervasive developmental disorder	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Pharyntgitis	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Sinusitis	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Speech Delay	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Strep Throat	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Syphilis/Chlamydia/STD	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Tourette's	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Yeast Infections	<input type="checkbox"/>	Never	<input type="checkbox"/>	Past	<input type="checkbox"/>	Yes:	_____
Other	_____						
Other	_____						

ALLERGIES:

Is child SENSITIVE/INTOLERANT/ALLERGIC to any of the following foods?

Milk/Dairy Wheat/Gluten Peanuts Soy Eggs Corn Yeast Chocolate Citrus Fish/Shellfish Strawberries
 Other: _____

Do you live with any pets? No Yes Describe _____

Please list any allergies that your child has been diagnosed with or that you suspect. _____

Does anyone in the home smoke? Never No Yes Type: Cigarettes Cigars Pipes Other _____ Number/day: _____

MEDICATIONS: Is child currently taking (or recently discontinued) any PRESCRIBED medications?

Please List _____

OPERATIONS AND HOSPITALIZATIONS: No Yes Yr/Description _____

DEVICES: Please circle any of the following that the child utilizes:

Ear Tubes, Eyeglasses, Contact Lenses, Dental Braces, Back Brace, Knee Brace, Neck Brace, Implants, and/or Shunt.

How is child's dental health? Excellent Good Fair Poor

Has child had EYE exam? No Yes Date Last Exam _____
 Has child had HEARING exam? No Yes Date Last Exam _____

TESTS: Has child ever had an X-ray, CAT-Scan, MRI, Sonogram, PET-scan, EKG or Bone Scan (circle which test) of:
 No Yes Yr/Test/Result _____

FAMILY HISTORY: Has any blood relative (NOT CHILD) ever had any of the following?

ADD/AD(H)D	No	Yes	Relation	_____
Arthritis	No	Yes	Relation	_____
Asperger's Syndrome (AS)	No	Yes	Relation	_____
Asthma	No	Yes	Relation	_____
Autism	No	Yes	Relation	_____
Bleeding Disorder	No	Yes	Relation	_____
Bipolar Disorder	No	Yes	Relation	_____
Cancer	No	Yes	Relation	_____
Developmental Delay	No	Yes	Relation	_____
Diabetes Type I / II	No	Yes	Relation	_____
Emphysema	No	Yes	Relation	_____
Hepatitis B or C	No	Yes	Relation	_____
Hypothyroidism	No	Yes	Relation	_____
Learning Disability	No	Yes	Relation	_____
Mental Illness/Suicide	No	Yes	Relation	_____
Migraine Headaches	No	Yes	Relation	_____
Multiple Sclerosis	No	Yes	Relation	_____
Obsessive Compulsive Disorder (OCD)	No	Yes	Relation	_____
PDD	No	Yes	Relation	_____
Siezure Disorder/Epilepsy	No	Yes	Relation	_____
Speech Delay	No	Yes	Relation	_____
Tourette's Syndrome	No	Yes	Relation	_____

DIET AND NUTRITION: Does child consume any of the following?

Milk Dairy No Rarely Often Approx glasses/day _____
 Difficulty digesting Milk/Dairy (Lactose Intolerant) No Not Aware Yes
 Wheat/Gluten containing grains/cereals No Rarely Often
 Soda/Cola No Rarely Often Approx glasses/day _____ Type _____
 Juices-Orange/Apple No Rarely Often Approx glasses/day _____
 Water directly from Tap Never/Rarely Sometimes Mostly
 Soy-Containing Foods No Occasionally Often – (Circle) Soy milk Tofu Soy Protein Times/Week: _____

How many meals plus snacks per day does child eat on average? 1 2 3 4 5 Graze

Does child eat fruits and vegetables? Frequently Rarely Almost Never

How many times/week, on average, does child eat Fish/Seafood? More than 3 Rarely 1 – 2X/Wk Almost Never

Which Fats/Oils does child consume?

Butter Olive Oil Coconut Oil Flax Oil Safflower Oil Sunflower Oil Peanut Oil Grape Seed Oil Macadmaia Oil
 Mayonnaise Margarine Crisco Corn Oil Soybean Oil Canola Oil

Is Child in any special diet?

Dairy-Free Wheat/Gluten-Free Yeast-Free Feingold Low Carbohydrate High Protein No Special Diet

Other: _____

What diet type does child primarily consume?

- High Carbohydrate – Bread, pasta, cereal, rice, potatoes, juices, sweets, etc
- High Protein – Meat, fish, fowl, eggs, nuts, etc.
- Vegetarian – No meat at all
- No Special Diet – Large variety of protein, vegetables, and carbohydrates

Please list the foods in child’s “usual” (Please be specific):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Other _____

Name the five foods consumed MOST frequently (Please be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

List all vitamins, minerals, herbs, amino acids, and nutritional supplements (with dose) you are taking on a regular basis:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. What was the name of the Jetson’s dog? _____

*Directions: Circle impression of the following using grading system “0” not at all to “10” very severe.

Psychological/Emotional

Seems angry at times	0	1	2	3	4	5	6	7	8	9	10
Seems depressed	0	1	2	3	4	5	6	7	8	9	10
Picks on other children	0	1	2	3	4	5	6	7	8	9	10
Disliked by other children	0	1	2	3	4	5	6	7	8	9	10
Has difficulty making friends	0	1	2	3	4	5	6	7	8	9	10
Shows poor self-esteem	0	1	2	3	4	5	6	7	8	9	10
Violent behavior	0	1	2	3	4	5	6	7	8	9	10
Immature behavior	0	1	2	3	4	5	6	7	8	9	10
Physically hurts self or others	0	1	2	3	4	5	6	7	8	9	10
											Score _____

Attention/Hyperactivity

Trouble staying seated for class work	0	1	2	3	4	5	6	7	8	9	10
Fidgets excessively in seat	0	1	2	3	4	5	6	7	8	9	10

Easily distracted	0 1 2 3 4 5 6 7 8 9 10
Acts before thinking	0 1 2 3 4 5 6 7 8 9 10
Interrupts, often calls out	0 1 2 3 4 5 6 7 8 9 10
Requires assistance to accurately complete assignment	0 1 2 3 4 5 6 7 8 9 10
Excessively stares or appears "spaced out"	0 1 2 3 4 5 6 7 8 9 10

Academic

Disorganized	0 1 2 3 4 5 6 7 8 9 10
Loses things needed for tasks	0 1 2 3 4 5 6 7 8 9 10
Poor math/science skills	0 1 2 3 4 5 6 7 8 9 10
Slow to begin/finish schoolwork	0 1 2 3 4 5 6 7 8 9 10
Poor memory	0 1 2 3 4 5 6 7 8 9 10
Forgetful about school assignments and tasks	0 1 2 3 4 5 6 7 8 9 10
Makes careless errors or mistakes	0 1 2 3 4 5 6 7 8 9 10
Poor penmanship	0 1 2 3 4 5 6 7 8 9 10
Has trouble following teacher instructions/group direction	0 1 2 3 4 5 6 7 8 9 10

Score_____

MAIN REASON AND GOALS OF APPOINTMENT:

Please honestly rate your ability, resources, and desire to make the necessary lifestyle, medical, dietary, supplement, and nutrition commitments and modifications for your child in order to significantly impact the typical "natural" course of current disease or disorder.

Likely only minor changes Likely only moderate changes Likely I can make major changes I can do almost everything it may take

Do you freely choose and desire Complementary/Integrative/Alternative treatment(s) for your child's medical condition(s) and understand that along with the significant benefits that can often be achieved there may always be, as with all treatments, some inherent risk? YES NO

To the best of my knowledge all of the above information is true and accurate.

Parent/Guardian Signature:_____

For Patient:_____ Date:_____