

**COMPREHENSIVE PEDIATRIC MEDICAL HISTORY**

*Confidential Medical Record – Unauthorized Use Strictly Prohibited*

|                            |                            |                                  |              |
|----------------------------|----------------------------|----------------------------------|--------------|
| Patient Name               |                            | Date                             |              |
| Street Address             |                            | City/State                       | Zip Code     |
| Guardian Home Phone<br>( ) | Guardian Work Phone<br>( ) | Guardian Cell Phone/Pager<br>( ) |              |
| 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 |
|---------------------------|-----------------|-------------------------|

**Referred by:**

|  |   |                                |
|--|---|--------------------------------|
| <input type="checkbox"/> Patient Name: | <input type="checkbox"/> Physician Name | <input type="checkbox"/> Other |
|--|---|--------------------------------|

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____. |                   |
| <b>Signature:</b>  | <b>Witnessed:</b> |

**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 |
|--------|-----|--------|--------|------|-----------------|
|--------|-----|--------|--------|------|-----------------|

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 1<sup>st</sup> 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:**

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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:\_\_\_\_\_