

Children's Health History

Please Print

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parents/Guardians _____ E-mail _____

Home Phone: _____ Cell #: _____ Work # _____

Age: _____ Birth Date: _____ Sex: M F Siblings ages _____

Activities / sports / hobbies: _____

Family's activities / interests: _____

Who will be responsible for payment? Parent/Guardian _____ Other _____

I intend to pay for my child's care by: Cash _____ Check _____ Credit Card: _____

Will there be an insurance claim involved? Yes / No

Type Policy: Personal _____ Group Health _____ Auto _____ Personal Injury _____

I was referred to this office by: _____

I have heard about your office from: (please circle all that apply) Newspaper Mailing Internet Phonebook
Insurance Friend Location Other _____

Health History:

My reason for today's visit is _____

How is this affecting life/activities? _____

Pregnancy History:

Was there any history of trauma? _____

How many ultrasounds were performed? _____ Any other invasive tests? _____

Labor & Delivery was (check all that apply): Normal _____ Drug induced _____ Forceps/Vacuum extraction _____

Breach _____ Dr. pull or twist baby _____ Premature delivery _____ C-section _____ Prolonged labor _____ (hrs _____)

Epidural _____ Other: _____

Physical Stresses:

List any Falls, Jolts, or Impacts: _____

Sports Injuries: _____

Broken Bones: _____

Accidents: (Auto, Bike, Bus, etc. Please provide dates and severity of injuries.) _____

Physical Stresses (ctd):

Hospitalizations/surgeries: (dates and reason) _____

List Prolonged or frequent childhood illnesses: (Ear Infections, Asthma, Allergies, etc.)

Sleep problems _____

Developmental disorders or delays _____

Age first crawled _____ walked _____ Was child frequently in walker? _____

Chemical Stresses:

During pregnancy was there use of alcohol ___ tobacco___ drugs/medicines_____

Has your child received vaccinations: No / Yes (which ones?) _____

Is there history of prolonged or frequent use of medication? No / Yes (what & why) _____

Allergies: No / Yes (to): _____

Was your child breast-fed? Y/N How long?_____ Challenges _____

How would you rate your child's diet? _____ Are there any food cravings? _____

List weekly intake of: Caffeine _____ NutraSweet _____ Sweets _____ Fast Food _____

Mental Stresses:

Major stresses during pregnancy: _____

Known psychological disorders: _____

Rate child's level of mental stress: Very High ___ High ___ Moderate ___ Low ___ Very Low ___

Other stresses with school/peers/activities? _____

Previous Health Care:

Family Physician: Dr. _____ Phone # (if known) _____ - _____

Last visit: _____ Why _____

Previous Chiropractic Care: Dr. _____ Last visit: _____

Reason for care _____ How long under care _____

Would you object to us conferring with your previous or other physicians about care if necessary? No / Yes

Expectations for care: Relief Only ___ Correction of Problem ___ Prevention of Health Problems ___

Family Wellness Care _____ Other _____

All of the statements made on this form are accurate and complete to the best of my recollection.

Patient/Parent/Guardian: _____ **Date:** _____