

**Child Health History Form**

**Child’s Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender:** [ ] **M** [ ] **F**

**Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Is this a cell phone?** [ ] **Y** [ ] **N )**

**Parent’s email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Reason for Visit Mother’s Pregnancy & Labor**

[ ]  Wellness [ ]  Specific Condition *During the pregnancy, did the mother:*

Describe the purpose of the visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ …. take any medication?  [ ]  Yes [ ]  No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the purpose of the visit related to: …. smoke or consume alcohol? [ ]  Yes [ ]  No

[ ] sports [ ] auto [ ]  fall [ ]  home injury

 …. Experience any illness?[ ]  Yes [ ]  No

[ ] chronic discomfort [ ] other Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was labor chemically induced?[ ]  Yes [ ]  No

When did this condition begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was labor doctor assisted?[ ]  Yes [ ]  No

Has this condition: Was a C-Section performed?[ ]  Yes [ ]  No

[ ]  gotten worse [ ]  stayed constant [ ]  comes and goes

 Were forceps or vacuum extraction used?[ ]  Yes [ ]  No

Does this condition interfere with:

[ ]  sleep [ ]  daily routine [ ]  other activities Did the delivery doctor pull or twist the baby [ ]  Yes [ ]  No

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ during delivery?

Has the condition occurred before? [ ]  Yes [ ]  No Was the delivery premature? [ ]  Yes [ ]  No

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If “Yes”, at \_\_\_\_\_\_\_ weeks and \_\_\_\_\_\_\_ weight

Have you seen other doctors for this condition? [ ]  Yes [ ]  No Check any of the following if the child experienced it immediately after

Doctor’s Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ birth:

Type of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  jaundice [ ]  respiratory problems

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  feeding problems [ ]  displaced or broken joints

 [ ]  other conditions

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Child’s Health History**

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall course of care for your child.

[ ]  Vision Problems [ ]  Headaches [ ]  Sleeping Disorder [ ]  Irritability [ ]  Skin Problems [ ]  Allergies

[ ]  Breathing Problems [ ]  Asthma [ ]  Constipation [ ]  Pink Eye [ ]  Ear Problems [ ]  Tubes in Ears

[ ]  Attention Problems [ ]  Frequent Colds [ ]  Digestive Problems [ ]  Colic [ ]  Hyperactivity [ ]  Bed Wetting

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Child’s Current Health Status**

Is your child accident prone?  [ ]  Yes [ ]  No

Has your child:

 ….. been hospitalized? [ ]  Yes [ ]  No

 ….. had a severe fall? [ ]  Yes [ ]  No

 ….. been in a car accident? [ ]  Yes [ ]  No

Has your child ever taken antibiotics? [ ]  Yes [ ]  No

 If “Yes”, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently taking any medication? [ ]  Yes [ ]  No

 If “Yes”, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have difficulty interacting with schoolmates or friends? [ ]  Yes [ ]  No

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? [ ]  Yes [ ]  No

What changes (if any) in your child’s health or behavior would you like accomplished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Vaccinations**

Have you chosen to vaccinate your child? [ ]  Yes [ ]  No

 [ ]  CDC Recommended Schedule

 [ ]  Delayed Vaccination Schedule

 [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any and all reactions to vaccine(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Goals for my Child’s Care**

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others the correction of whatever

is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your child’s Chiropractic care program. Please

check the type of care desired so that we may be guided by your wishes whenever possible.

[ ]  **Relief Care** [ ]  **Corrective Care**  [ ]  **Wellness Care**

 Symptomatic relief of pain and discomfort. Correcting and relieving the cause of the Bring whatever is malfunctioning in the

 problem as well as the symptoms. body to the highest state of health

 possible with Chiropractic care.

[ ]  I want my Doctor to select the type of care appropriate for my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Printed Name Parent/Guardian Signature Date