Children's Health History Form

Date: _____

Name: _____ Age: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Father's Name: _____

Phone #: _____ Date of Birth: _____

Reason for consulting our office:

If your child has no symptoms or complaints, and is here for ***wellness*** services, please check here _____

Others, please briefly describe the ***chief area of complaint***, including the affect it has on the child's life:

If he/she is experiencing pain, is it…

Sharp Dull Comes & Goes Travels Constant

Since the problem started, it is…

About the same Getting better Getting worse

What makes it worse? _____

This Condition interferes with: School Sleep Walking Sitting Hobbies

Other Doctors seen for this problem:

Chiropractor: _____ Date of last visit: _____

Medical Doctor: _____ Date of last visit: _____

Other: _____

List any ***medications or supplements*** the child is taking:

Child's Name: _____ Date of birth: _____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering the following questions will give us a profile of the specific stresses your child has faced in their lifetime, allowing us to better assess the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was mom on any medications, prescription or over-the-counter? _____

Did Mom or Dad smoke during pregnancy? YES/NO If yes, who? _____

Was the baby ever in the breach position? YES/NO How many ultrasounds were performed?

Birth and Delivery:

The baby was born: In a hospital At home In a birthing center Other

The delivery was: Vaginal/Cesarean Were any devices used to assist? Forceps/Vacuum

How long was the labor? _____ How long was the delivery? _____

Infancy:

Was the infant vaccinated? YES NO

Was there any prolonged use of medicine such as antibiotics or an inhaler? YES NO

Did the infant suffer from any traumas such as serious falls or car accidents? YES NO

Childhood Years:

Did/does the child have any childhood illnesses? YES NO

If yes, explain: _____

Does the child play youth sports? YES NO

Has the child had any surgery? YES NO

If yes, explain: _____

Was the child involved in any car accidents? YES NO

If yes, explain: _____

Any prolonged use of medications? YES NO

Has the child suffered any traumas (physical or emotional)? YES NO

If yes, explain: _____

Has the child jumped/fallen from a height of over 3 feet? YES NO

Please give us any other information you feel would be helpful:

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to examine my child for further evaluation.

Parent/Guardian's signature: _____ Date: _____

Print Name: _____