

CHILD HEALTH HISTORY

We are happy you have chosen to have your child's spine checked! Many types of stresses (physical, mental, and chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so PLEASE ask questions.

Child's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State/Zip: _____

Parents Email: _____ Home Phone #: _____ Parents Cell Phone #: _____

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

Names & Ages of Siblings: _____

Reasons For Consulting Our Office: _____

Referred By: _____

Previous Chiropractic Care? Yes No If Yes, With Whom? _____

How Long Was Care Received? _____

Reason For Stopping Care? _____

Background Information:

(Check Off Appropriately)

Birth Place: Home Birth Center Hospital

Type: Vaginal C-Section

Procedures: Forceps Vacuum Extraction

Was Delivery Long? Yes No

Was Delivery Difficult? Yes No

Labor Induced? Yes No

Epidural? Yes No

Pain Medication? Yes No

Was Baby Breech/in Utero-Constraint? Yes No

Was Baby Breast Fed? Yes No

How Long? _____

Which sports does/did your child participate in:

Soccer Football Gymnastics Cheerleading

Karate Basketball Dance Lacrosse

Other: _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child?

Yes No

Comments: _____

List any other fall or accidents: _____

Check any of the following your child has suffered from:

Ear Infections Scoliosis Seizures

Chronic Colds Asthma/Allergies Colic

Digestive Problems Headaches A.D.D.

A.D.H.D. Recurring Fevers Growing/Back Pains

Bed Wetting Constipation Head Banging

Other ailments your child has suffered from: _____

CHILD HEALTH HISTORY (CONTINUED)

Child's Name: _____ Date of Birth: _____ Age: _____

Medications:

How many rounds of antibiotics has your child taken in last 6 months? _____ Lifetime? _____

Present Prescription Drugs: _____

Past Prescription Drugs: _____

Over the Counter Drugs (*Tylenol, cough syrups, laxatives, etc.*): _____

Financial Information:

Who is responsible for this account? _____ Relationship: _____

Date of Birth: _____

Employer: _____

What method of payment will you be using? Insurance Cash Check Other: _____

Insurance Company: _____ Policy/ID#: _____

Address: _____ Phone #: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize: _____ and whomever they may designate to administer care to my son/daughter:

Name _____
Date

Signature _____
Witness (office use only)

Signature of Parent or Guardian (if minor) _____
Relationship