CHIROPRACTIC | DESIGNED CLINICAL NUTRITION

ALIVE & WELL

Child Health History - Nutrition

NAME: ____DATE: ___________________

PARENTS/GUARDIAN: ____

ADDRESS: ____

CITY/STATE: __________________________________ZIP CODE: _______________

HOME PHONE: ____________________WORKPHONE: ________________________

BIRTHDATE: ______________OTHER CHILDREN NAMES/AGES_______________

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WHO REFERRED YOU TO THIS OFFICE: ______________________________________

PAST NUTRITIONAL CARE? YES/NO, DR.'S NAMES/LOCATION: ____________

____LAST VISIT: _______________

CURRENT MEDICAL CARE? YES/NO WHY: _________________________________

CURRENT DRUGS/MEDICATION: ____

REASON FOR CONSULTING THIS OFFICE: ________________________________

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PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR CHILD'S HEALTH/WELLBEING.

☐ I am only concerned about relief of a particular symptom.

☐ I am only concerned about relief of a particular symptom and preventing its return.

☐ I want optimum health and wellbeing on every level for my child.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service.

Signature: ____Date: _______________

PLESE TELL US ABOUT ANY STRESS ASSOCIATED WITH BIRTH:
(Please circle any that apply)

During Pregnancy:
1) Drugs/medicine ☐Yes ☐No
2) Tobacco/alcohol ☐Yes ☐No
3) Illness during ☐Yes ☐No
Explain: ______________________________
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During Labor & Delivery:
1) Labor chemically induced ☐Yes ☐No
2) Labor doctor assisted ☐Yes ☐No
3) C-section delivery? ☐Yes ☐No
4) Forceps/vacuum extraction? ☐Yes ☐No
5) Doctor pull or twist baby? ☐Yes ☐No
6) Premature delivery? ☐Yes ☐No
Explain: ______________________________
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Since Birth:
1) Nursed how long? _________________
2) Baby Jaundiced? ☐Yes ☐No
3) Feeding Problems? ☐Yes ☐No
4) Sleeping Problems? ☐Yes ☐No
5) Colic? ☐Yes ☐No
6) Vaccinations? ☐Yes ☐No
Explain: ____________________________
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PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

1) Any falls or injuries? ☐Yes ☐No
2) Respiratory problems? ☐Yes ☐No
3) Ear infections? ☐Yes ☐No
4) Allergy/Asthma? ☐Yes ☐No
5) Bedwetting? ☐Yes ☐No
6) Digestive problems? ☐Yes ☐No
7) Hyperactivity? ☐Yes ☐No
8) Other health problems? ☐Yes ☐No
9) Hospitalized? ☐Yes ☐No

Explain: ____________________________
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Anything else: ____
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I hereby authorize the above-named doctor(s) and whoever may be designated as assistants; to provide nutritional care as may be deemed necessary to my child.

Signature: ____ Date: ______________