



Child Health History

NAME: _____ DATE: _____

PARENTS/GUARDIAN: _____

ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORKPHONE: _____

BIRTHDATE: _____ OTHER CHILDREN NAMES/AGES _____

WHO REFERRED YOU TO THIS OFFICE: _____

PAST CHIROPRACTIC CARE? YES/NO, DR.'S NAMES/LOCATION: _____

_____ LAST VISIT: _____

CURRENT MEDICAL CARE? YES/NO WHY: _____

CURRENT DRUGS/MEDICATION: _____

REASON FOR CONSULTING THIS OFFICE: _____

**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, unless other arrangements have been made and agreed upon writing.

Signature: _____ Date: _____

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of vertebral subluxations.

Stress that may be physical, chemical or emotional may cause these subluxations.

The practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation.

PLEASE 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: _____

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: _____

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: _____

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: _____

Anything else: _____

I hereby authorize the above-named doctor(s) and whoever may be designated as assistants; to provide chiropractic care as may be deemed necessary to my child/ward.

Signature: _____ Date: _____