CHILDREN'S HEALTH RECORD

Please fill out all information completely

Name:_____ Nickname:_____
Address:_____
City, State, Zip Code:_____ Date of Birth: _____/_____/_____
Sex: O Male O Female Parent(s) Name: _____
Parent Phone: ( ) _____ O Home O Cell O Work Parent E-mail: _____
Parent Occupation: _____ Parent Employer: _____
Who may we thank for referring you to our practice?: _____
Has your child been to a Chiropractor in the past? O Yes O No Last adjustment: _____
Would you like appointment reminders? O via Text (Cell Provider: _____) OR O via Email
Choose: O Same Day OR O Day Before

CHILD'S BIRTHING HISTORY

During pregnancy, did the mother:

…take any medication? O Yes O No Explain:_____
…smoke or consume alcohol? O Yes O No Explain:_____
…experience any illness? O Yes O No Explain:_____
…have any complications? O Yes O No Explain:_____
What things were done to stay healthy during pregnancy? _____

Type of birth: O Vaginal O Cesarean
Provider: O Midwife O OB-Gyn O Other
Were pain medications used? O Yes O No
Pitocin used? O Yes O No
Was labor induced? O Yes O No
Did any of the following occur during labor:
O Birth trauma O Doctor assisted labor
O Twisting/Pulling O Vacuum/Forceps
Was the delivery premature? O Yes O No
If "Yes", at _____ month and _____ weight
Approximately how long did labor last? _____ Hours

Check any of the following if the child experienced it immediately after birth:

O Jaundice O Respiratory Problems
O Feeding Problems O Displaced or Broken Joints
O Other Condition(s):_____

Did your child have a misshaped skull/head O Yes O No
Did your child breast-feed? O Yes O No
How long? _____

CHILD'S HEALTH HISTORY

Has your child ***ever*** experienced or been diagnosed with any of the following:

O Ear problems	O Colic	O Sleeping problems	O Skin problems
O Infections	O Anemia	O Frequent fever	O Seizures
O Reflux	O Diarrhea	O Constipation	O Repeated colds
O Breathing problems	O Irritability	O Tonsillitis	O Vision problems
O Allergies	O Asthma	O Learning difficulties	O Hyperactivity
O Attention problems	O Spectrum disorder	O Headache	O Bed wetting
O Stomach pains	O Anxiety	O Leg/knee pain	O Low energy
O Neck/Back pain	O Scoliosis	O Growing pains	O Menstrual cramps
O Migraine	O Depression	O Low self-esteem	O Other: _____

Has your child experienced any:
…surgeries?: _____
…illnesses/diseases?:_____
…car accidents?:_____
…severe falls?:_____
….broken bones?:_____

Has your child ben on antibiotics? O Yes O No
If yes, how often and for what purpose?:_____
Is your child currently taking any medication? O Yes O No
If yes, how often and for what purpose?:_____
Is your child currently taking any vitamins? O Yes O No
If yes, how often and for what purpose?:_____

Does your child participate in any extra-curricular activities? O Yes O No
If yes, which ones?:_____
Rate your child's diet: O Well-balanced O Average O High sugar/processed foods
How many hours does your child typically sleep?: _____ hours/day
Rate your child's sleep quality: O Good O Fair O Poor

REASON FOR THIS VISIT

What is the reason for your child's visit today? O Wellness check-up O Other:_____
_____
If other, how long has this been a concern?_____
Is the concern getting worse? O Yes O No O Not sure
Does it affect activity? O Not at all O Somewhat O Always
Has anything been done to address this concern?_____
_____

Does the child have a family history (parent/sibling/grandparent) of any of the following?
O Heart Disease O Arthritis O Cancer O Diabetes O Multiple Sclerosis O Other: _____

What changes (if any) in your child's health or behavior would you like accomplished?_____
_____

Is there anything else that you would like the Chiropractor to know?_____
_____

_____ _____
Patient Name (print) Parent/Guardian's Name (print)

_____ _____
Parent/Guardian's Signature Date