4 CHILD'S HEALTH HISTORY

Family Medical Physician (Name, Address, Phone)

____

Check the following conditions your child has suffered from in their lifetime:

Has your child ever been to a chiropractor?

Birth

Condition		
Breech	☐yes	☐No
C-section	☐yes	☐No
Forceps	☐yes	☐No
Natural	☐yes	☐No
Suction Cup	☐yes	☐No

Other___________________

Condition		
ACHD	☐yes	☐No
Allergies	☐yes	☐No
Appendicitis	☐yes	☐No
Asthma	☐yes	☐No
Bed Wetting	☐yes	☐No
Bowel Problems	☐yes	☐No
Car Accident	☐yes	☐No
Chicken Pox	☐yes	☐No
Colic	☐yes	☐No

Condition		
Digestive Problems	☐yes	☐No
Ear Infections	☐yes	☐No
Growing Pains	☐yes	☐No
Headaches	☐yes	☐No
Juvenile Arthritis	☐yes	☐No
Measles	☐yes	☐No
Mumps	☐yes	☐No
Pneumonia	☐yes	☐No

Condition		
Recurring Colds	☐yes	☐No
Recurring Flues	☐yes	☐No
Recurring Strep/ Sore Throats	☐yes	☐No
Seizures	☐yes	☐No
Stomach Ulcers	☐yes	☐No
Temper Tantrums	☐yes	☐No
Tonsillitis	☐yes	☐No
Vaccinations	☐yes	☐No

Other ____________________

__________________________ If yes, when? ____________________ Reason? _________________

Which contact sports does your child participate in? (circle) Soccer / Football / Gymnastics / Karate / Hockey / Basketball / Dance / Other ____________________

According to the National Safety Council, approximately 50% 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 (If yes, explain below under injuries/surgeries)

How many prescriptions of antibiotics has your child taken: During the past 6 months? _____________ During his/her life? ____________

How many other prescription medications has your child taken: During the past 6 months? __________ During his/her life? ____________

Injuries/Surgeries your Child has had:	Description	Date
Falls	____________________	____________
Head Injuries	____________________	____________
Broken Bones	____________________	____________
Dislocations	____________________	____________

Surgeries ____

5 MEDICATIONS (Prescription and over the counter), VITAMINS/HERBS/SUPPLEMENTS

____

____

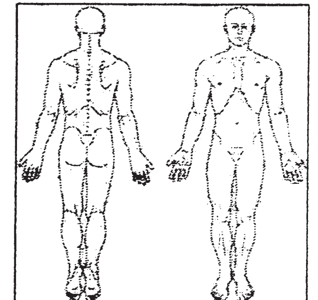
6 PATIENT CONDITION

Today's Health complaint:____

When did this symptom(s) appear? ______________________________________

Is this condition getting progressively worse? ☐Yes ☐No ☐Same

Mark an X on the picture where these symptoms are located (if applicable)



Type of pain (if applicable:) ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often is this symptom(s) present? ☐Occasional 0-25% ☐Intermediate 26-50% ☐Frequent 51-75% ☐Constant 76-100%

Does it interfere with ☐School ☐Sleep ☐Daily Routine ☐Recreation

Activities/movements that are difficult due to this symptom(s) ☐Eating ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down