

Child's Health History

Creative Chiropractic Solutions

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Name: _____ Age: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Mother's Name: _____ Father's Name: _____
Phone #: _____ SSN: _____ DOB: _____ Sex; M F
Reason for consulting our office: _____

Whom may we thank for referring you? _____

Health Profile



Why is this form important?

As a Family Chiropractic Office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the Issues That Brought You to the Office

If your child has no symptoms or complaints, and is here for wellness services, please check ; others need to briefly describe the chief area of complaint, including the effect it has on the child.

If he/she is experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant

Since the problem started, is it: About the Same Getting Better Getting Worse?

What makes it worse? _____

It interferes with: School Sleep Walking Sitting Hobbies Other: _____

Other doctors seen for this problem:

Chiropractor: _____

Medical Doctor: _____

Other: _____

List medications the child is taking or surgeries the child has had:



Daily, we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

PREGNANCY:

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? Yes No

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? Yes No Who? _____

Was the baby ever in the Breech position? Yes No

How many ultrasounds were performed? _____

BIRTH AND DELIVERY:

Where was the baby born? _Home _Hospital _Birthing Center _Other: _____

Was the delivery _Vaginal _C-Section Were any devices used? _Forceps _Vacuum

How long was the labor? _____ How long was the delivery? _____

Was oxytocin/pitocin used? Yes No Was an epidural administered? Yes No

INFANCY:

Was the infant vaccinated? Yes No

Was there any prolonged use of medicines or an inhaler? Yes No If yes, which: _____

Did the infant suffer any traumas such as serious falls or car accidents? Yes No

Has the infant been under regular chiropractic care? Yes No

CHILDHOOD YEARS:

Did the child have any childhood illnesses? Yes No Explain: _____

Does the child play youth sports? Yes No Which sport? _____

Has the child had any surgery? Yes No Explain: _____

Has the child fallen from a height over 3 ft? Yes No Explain: _____

Was the child involved in any car accidents? Yes No When? _____

Has there been any prolonged use of meds? Yes No Explain: _____

Has the child suffered emotional traumas? Yes No Explain: _____

Please give us any other health information you feel would be helpful: _____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to Chiropractically examine and care for my child.

Parent's signature: _____

Date: _____