CHILD 5-18 HEALTH HISTORY

Welcome! *Please complete this form and bring it to your first appointment.*

PERSONAL / PARENTAL CONTACT INFORMATION

Child's Name: Birth date: Age:

Gender: ☐ Female ☐ Male ☐ Other

Parents' names:

Address: City: Postal Code:

Home#: Mobile #:

E-mail:

How did you hear about our office? ☐ Website ☐ Internet ☐ Location ☐ Referral:

Has your child ever been to a chiropractor before? ☐ Yes ☐ No

Name of chiropractor: City:

Date of last visit: Duration and frequency of care:

GROWTH AND DEVELOPMENT

Any concerns regarding your child's development pattern? ☐ Yes ☐ No Describe:

Any concerns regarding your child's sleep patterns? ☐ Yes ☐ No Describe:

Family history of health problems (cancer, diabetes, heart disease, other):

Mother's side: Father's side: Siblings:

PSYCHOSOCIAL STRESSORS

Any behavioral difficulties? ☐ Yes ☐ No Describe:

Night terrors, sleepwalking, sleep trouble? ☐ Yes ☐ No Describe:

Does your child have challenges regulating emotions? ☐ Yes ☐ No Describe:

Does your child experience anxiety? ☐ Yes ☐ No Describe:

Does your child have difficulty focusing/concentrating? ☐ Yes ☐ No Describe:

Does your child have difficulty with loud noises or bright lights? ☐ Yes ☐ No Describe:

What is the average # of hours of screen time (TV, tablet, phone or computer) per week?

PHYSICAL STRESSORS

Any physical trauma, falls, injuries in sports, car accidents? ☐ Yes ☐ No Describe:

Any stitches, fractures, or bruises? ☐ Yes ☐ No Describe

Any hospitalizations? ☐ Yes ☐ No Describe:

Any surgeries? ☐ Yes ☐ No Describe:

What sports does your child play? # hours per week?

Any hobbies that involve repetitive motion? (Musical instrument, video games, other…)

What would you like to gain from chiropractic care?

Any other concerns we should know about?

How can we make your experience in our office even better?

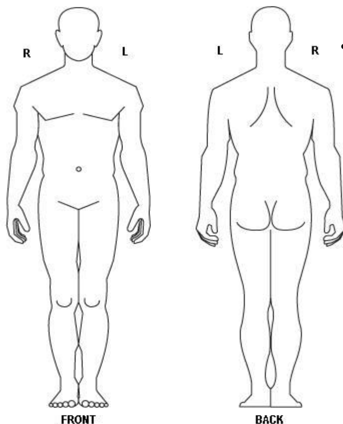
PHYSICAL AND SYMPTOM LOCATION

Please list and describe your Health Concerns in order of severity:

Pain Level 1-10, 0 = no pain, 10 = excruciating).

Feels like examples: sharp, dull, throbbing, burning, aching, stabbing, etc.

1st Health Concern:	
When did you first notice it?	What makes it feel worse?
How often do you feel it?	
Getting better or worse?	
Pain Level (1-10):	What makes it feel better?
What does it feel like?	
Doctor's notes:	
2nd Health Concern:	
When did you first notice it?	What makes it feel worse?
How often do you feel it?	
Getting better or worse?	
Pain Level (1-10):	What makes it feel better?
What does it feel like?	
Doctor's notes:	
Additional Health Concerns	



Please mark the area of your symptoms with an 'X' on the diagram:

Does this affect your work, personal life, mood, or quality of life?

□ No □ Yes - Describe:

Have you consulted any other health care providers? □ No □ Yes

If yes, list providers, diagnosis and treatment:

I give consent to receiving email reminders for my child's appointments:

Signature

Date