GENERAL HEALTH HISTORY (Child)

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Patient Name_____ Mark the conditions that apply to you.

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive Problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 months: _____ Total during lifetime: _____
3. Name of Pediatrician and Other Doctors: : _____
4. Date of Last Visit _____/_____/_____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ❑Hospital ❑Birthing Center ❑Home
7. Complications During Pregnancy: ❑No ❑Yes – Explain: _____
8. Ultrasounds During Pregnancy: ❑No ❑Yes – How Many? _____
9. Medication During Pregnancy / Delivery: ❑No ❑Yes – List? _____
10. Cigarette / Alcohol Use during Pregnancy: ❑No ❑Yes
11. Has any Doctor / Professional advised you to "Take the child to a Chiropractor": ❑No ❑Yes – Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries_____
15. Please describe any past conditions and treatment received: _____

_____

16. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____