CHILD HEALTH HISTORY

PERSONAL HISTORY (CHILD)

Name: _________________________ Birthdate: ____________ Sex: Male Female

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PERSONAL HISTORY (PARENT)

Name: _________________________ Birthdate: ____________ Sex: Male Female

Address: _________________________ Marital status: □ S □ M □ D □ W

City: _________________________ State: ____________ Zip: ____________

Home phone: _________________________ Cell phone: _________________________

Business phone: _________________________ Email: _________________________

Business employer: _________________________ Type of work: _________________________

Name of spouse: _________________________ Name and ages of children: _________________________

Referred to this office by: _________________________ Relationship: _________________________

Responsible for your bill? You and: □Spouse □Worker's Comp. □Auto Insurance □Medicare □Medicaid

□ Personal Health Insurance (Name):_________________________ Health Card #: _________________________

Insured person's name: _________________________ Date of Birth: _________________________

CURRENT HEALTH CONCERN

Unwanted condition: ____

How would you rate this pain, on average: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How much does it restrict his/her daily activities? None 0 1 2 3 4 5 6 7 8 9 10 Unable to Perform

Other doctors seen for this condition: □ Yes □ No Who? _________________________

REGARDING PREGNANCY

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages? ___________

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Was there back pain? ____

Approximately how long was the labor? ____

Were you physically ill at any point during the pregnancy (ie. colds, flu, allergies, etc.)? ____________________

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REGARDING LABOR

Was it chemically induced?	□ Yes □ No
Doctor assisted?	□ Yes □ No
Was a c-section performed?	□ Yes □ No
Were forceps used?	□ Yes □ No
Did doctor have hands on the infant?	□ Yes □ No
Were you lying down?	□ Yes □ No
Was a family member present?	□ Yes □ No
Was the baby premature?	□ Yes □ No If so, what was his/her age (weeks)? ____________

DID/DOES YOUR CHILD SUFFER FROM ANY OF THE FOLLOWING?

Headaches:	□ Yes □ No	Meningitis:	□ Yes □ No
Allergies:	□ Yes □ No	Diarrhea:	□ Yes □ No
Ear problems:	□ Yes □ No	Constipation:	□ Yes □ No
Sleeping problems:	□ Yes □ No	Colic:	□ Yes □ No
Breathing problems:	□ Yes □ No	Rashes:	□ Yes □ No
Fatigue:	□ Yes □ No	Milk or lactose intolerance:	□ Yes □ No
Irritability:	□ Yes □ No	Bed wetting:	□ Yes □ No
Hyperactivity:	□ Yes □ No	Digestive problems:	□ Yes □ No
Frequent colds:	□ Yes □ No	Other: ______________________	
Flu:	□ Yes □ No	______________________	
Bloody noses:	□ Yes □ No	______________________	

REGARDING YOUR CHILD TODAY

Is the child accident prone? □ Yes □ No Describe: ____

Has your child fallen down steps? □ Yes □ No Describe: ____

Has your child ever fallen from heights over 2 feet? □ Yes □ No Describe: ________________________

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Has your child ever been in a motor vehicle accident? □ Yes □ No

Has your child ever been hospitalized or had surgery? □ Yes □ No

Has your child had any broken bones, sprains, or sport injuries? □ Yes □ No Describe: _______________

Is your child on any medications? □ Yes □ No Describe: ____

Has your child had a scoliosis examination by an approved clinic? □ Yes □ No

Does your child own or use portable gaming devices or a cell phone? □ Yes □ No

If you could improve one aspect of your child's health or behavior, what would it be? _____________________

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I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge, and I understand that it is my responsibility to inform this office of any changes in my child's health.

I agree to allow this office to examine my child for further evaluation.

Parent or Guardian Signature: ___________________________________ Date: ________________________

Name of the child: __________________________________ Relationship to the child: _____________________