Child History Form

Ages: Birth-12 years old

Date:_____

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name:_____ Date of Birth:_____ Sex: M / F

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Email address:_____

Mother's Name:_____ Cell #:_____

Father's Name:_____ Cell #:_____

Child's Height:_____ Child's Weight:_____

Pediatrician's Name:_____

Office/Clinic Name:_____

Has the child ever seen a chiropractor? Y / N If yes, Doctor's Name:_____

Doctor's #:_____ Chiropractor's Office:_____

Date of Last Visit (dd/mm/yyyy):_____

What are your chief concerns, if any, with your child's health?

_____

_____

List any other care your child has undergone with regard to this complaint, including medication:

_____

_____

Date of onset (mm/yyyy):_____ Prior occurrence or episodes? _____

Onset was: Sudden / Gradual / Associated with an event

Duration of problem or episode: Minutes / Hours / Days / Months / Years

Pattern of Problem: Constant / Intermittent / Occasional / Cyclical

Aggravating Factors:_____

Relieving Factors:_____

How does the problem affect your child's body function and daily activities?

_____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature:_____ Date:_____