

INFANT & CHILD HEALTH HISTORY

(*We need a copy of current photo ID and insurance card if using insurance for services)

Name: _____ Date: ____ - ____, 20__

Birth Date: _____ Age: _____

Parent(s): _____

Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

Cell Phone of Parent That Brings Child to/from Visits: _____

Emergency Contact: _____ Ph: _____

Pediatrician/Primary Care Physician: Y/N

Name: _____ MD DO Ph: _____

Address: _____ City: _____ ST: ____ Zip: _____

Health Profile:

Reason for visit today: _____

What are you hoping Chiropractic care will do for your child? _____

Does child eat a healthy diet? Yes/No

Daily Fluid Intake: _____

Vitamins/Minerals/Supplements: _____

Sleep Patterns/Habits: _____

Vaccines: Y/N Following/Followed Doctor/Clinic Recommendations? Y/N

Reactions to any vaccines?: _____

*(☺*If you would like information regarding the dangers of vaccines and how to refuse them, let us know!)*

Had any 'Common' Childhood Diseases? Y/N, _____

Currently Taking Medications?: _____

Ever Taken Antibiotics?: When/Why? _____

Sports?: _____

Any Contact Sport Injuries? When/What? _____

Car Accidents? When? _____

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Falls? How/When? _____

Surgeries: _____

Other Traumas: _____

Learning/Behavior Disabilities: _____

Symptoms: Has your child ever experienced any of the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rashes | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Unusual Moles | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Arm/Elbow Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Leg/Hip Pain |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Digestive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Knee/Foot Pain |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Stomach Aches |

Prenatal History

Complications during pregnancy: Y/N List: _____

Any Genetic Disorders? List: _____

CONSENT TO CHIROPRACTIC CARE

The above information is correct and accurate to the best of my knowledge and as the parent/legal guardian of _____, I hereby grant permission for my child to receive chiropractic care.

Name: _____ Signed _____

Relationship to Child: _____ Witnessed _____

Date: ____ - ____, 20____

(If there is not enough room to answer any of the above, please ask for additional paper or use reverse)