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? ______________________
____
____

What foods does child eat on a daily basis? ____________________________________
____
Daily Fluid Intake: ____
Vitamins/Minerals/Supplements: ____
Breast-feeding/Breast fed? Y/N
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?____
____

Any Contact Sport Injuries? When/What? ______________________________________
____
Car Accidents? When? ____
Falls? How/When? ____

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____
Surgeries: ____
Other Traumas: ____

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

__Dizziness	**__Allergies**	**__Diarrhea**	**__Broken bones**
__ADHD	**__Runny Nose**	**__Poor Appetite**	**__Sprains/Strains**
__Backaches	**__Itchy Eyes**	**__Hyperactivity**	**__Hernias**
__Heart Condition	**__Rashes**	**__Behavioral**	**__Neck Pain**
__Chronic Earaches	**__Unusual Moles**	**__Poor Memory**	**__Arm/Elbow Pain**
__Diabetes	**__Neuritis**	**__Insomnia**	**__Leg/Hip Pain**
__Tuberculosis	**__Digestive**	**__Nightmares**	**__Knee/Foot Pain**
__Hypertension	**__Sinus Trouble**	**__Bed Wetting**	**__Growing pains**
__Fever/Chills	**__Cough/Wheeze**	**__Pain Urinating**	**__Joint Pain**
__Frequent Colds	**__Chest Pain**	**__Convulsions _Paralysis**	**__Scoliosis**
__Arthritis	**__Constipation**	**__Muscle Pain**	**__Blood disorders**
__Headaches	**__Anemia**	**__Fainting**	**__Stomach Aches**
__Asthma	**__Rheumatic Fever**		

Prenatal History

Location of Birth: __Home __Birthing Center __Hospital __Stepchild __Adopted
Complications during pregnancy: Y/N List: ____
____
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: __Forceps __Vacuum __Caesarian
Any Genetic Disorders? List: ____
Birth weight_______ Birth length________

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)

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