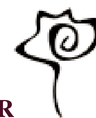
Children's Health History Form

ENGLANDER CHIROPRACTIC CENTER 

(to be filled out by parent or guardian)

Child's name: ____ Today's Date: ____________________
Birthdate: ________/_____/_________ Age: _______ Sex: _______ Height/Weight:____________/______________
Parent's (Guardian's) Name(s): ____
Address (city, zip): ____
Home Phone: _____________________ Cell Phone: ______________________Work Phone: ______________________
Email Address (we send appointment reminders by email): ____
Is/Are parents(s) single ______ married/partnered ______ divorced ______ widowed ______

What is your purpose for contacting us? ____
What other doctors have you seen for this condition? ____
What other health problems are present?____
____
Has your child seen a chiropractor previously? ____

Please check any of the following conditions your child has suffered from during the past six months:

- ☐ ear infections
- ☐ asthma
- ☐ colic
- ☐ scoliosis
- ☐ digestive problems
- ☐ bed wetting
- ☐ seizures
- ☐ ADHD
- ☐ car accident
- ☐ chronic colds
- ☐ recurring fevers
- ☐ temper tantrums
- ☐ headaches
- ☐ growing/back pain
- ☐ other

Number of rounds of antibiotics your child has taken: in past 6 months_______ in lifetime ________
Number of other prescription medications your child has taken: in past 6 months_______ in lifetime ________
List: ____
____

Vaccination History:____
____

Prenatal History:

OB/Midwife:____
Complications during pregnancy: Y N ____
Ultrasounds during pregnancy: Y N
Meds during pregnancy: Y N ____
Cigarette/alcohol use during pregnancy: Y N ____
Location of birth: Hospital___________________ Birthing Center___________________ Home____________
Birth interventions: forceps___ vacuum extraction___ c-section _______ (emergency? ___ planned?___)
Complications during delivery: ____
Genetic disorders or disabilities: ____
Birth weight: _________ Birth length:_________ APGAR: _________

Feeding History:

Breast fed: Y N How long?___________
Formula fed: Y N How long?___________ Type: _____________________
Introduced to solids at ________ months
Introduced to cow's milk at _________months
Food allergies/intolerances: Y N List: ____
____

Developmental History:

During certain developmental changes your child's spine is most vulnerable to stress and should routinely be checked by your chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference).
At (approximately) what age was your child able to:

Respond to sound ______
Respond to visual stimuli ______
Hold head up ______
Sit up ______

Crawl ______
Stand alone ______
Walk alone ______

Spinal Trauma History:

According to the national safety council, approximately 50% of children fall head first from a high place during their first year of life (eg., a bed, changing table, down stairs, etc.)

Has your child had any significant falls? Y N
Is/has your child been involved in any high-impact or contact sports (ie, soccer, football, gymnastics, basketball, hockey, martial arts, etc.)? Y N List: ____
Has your child ever been involved in a car accident? Y N List: ____
____
Has your child been to the emergency room? Y N describe: ____
____
Other traumas not described above: ____
____
Surgeries: ____
Childhood Diseases:

- ☐ chicken pox
- ☐ rubella (German measles)
- ☐ rubeola
- ☐ mumps
- ☐ whooping cough
- ☐ other___________________________

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

Authorization for care of minor:

I hereby authorize this office and its doctor to administer care to my child as deemed necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

____
Parent/legal guardian name printed

____
signature

____
date