Center for Life Chiropractic
Child Health History

Today's Date: _____/_____/_____ Child's Name: _____

Names of parents/guardians: _____ Phone #: (____)_____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____/_____/_____ SS#: _____-_____-_____ Sex: *Male* *Female*

Height: _____ Weight: _____ Allergies: _____

Medications: _____

Previous Chiropractor: _____ Date of last visit: _____

Pediatrician Name: _____ Date of last visit: _____

Prenatal History:

During pregnancy, did the mother…

Yes / No Smoke?

Yes / No Drink alcohol?

Yes / No Have a proper diet? Describe: _____

Yes / No Exercise throughout the pregnancy?

Yes / No Receive chiropractic adjustments?

Yes / No Experience any falls or injuries?

Yes / No Experience any mental or physical abuse?

Yes / No Receive prenatal ultrasounds? If so, how many? _____

Yes / No Take any prescription or over the counter medications? Please list:

_____

Birth History:

Regarding your child's birth:

Yes / No Was the delivery long? Length of labor: _____

Yes / No Was the delivery difficult?

Yes / No Was baby delivered with use of forceps?

Yes / No Was a vacuum extractor used?

Yes / No C-section? If yes, was it an emergency or planned: _____

Yes / No Was your baby in a breech position at the time of delivery?

Yes / No Were medications/anesthesia given during the labor? Which type? _____

Yes / No Complications during delivery? Please describe: _____

Where was your baby born? ___ Home ___ Hospital ___ Birthing Center ___Other: _____

Name of Obstetrician/Midwife: _____

Other information I'd like the doctor to know about the child's birth: _____

_____

(Please see reverse side)

Growth & Development:

At what age did your child…

_____ Eat solid food? _____ Stand alone? _____ Sit up? _____ Respond to sound?

_____ Hold head up? _____ Walk alone? _____ Crawl? _____ Respond to visual stimuli?

Yes / No Did your child breastfeed? For how long? _____

Yes / No Did your child crawl before learning to walk?

Yes / No Did your child have a serious fall down stairs, off of changing table, etc?

Yes / No Participation in contact or high impact sports? (Football, soccer, gymnastics, cheerleading, etc?)

If yes, please list: _____

Yes / No Has your child received regular chiropractic care?

Yes / No Has your child been in an auto accident? Please describe:

_____

Yes / No Has your child been taken to the ER? If yes, for what reason: _____

Yes / No Has your child broken any bones? Please list: _____

Yes / No Has your child undergone any surgeries? Please list: _____

Childhood Diseases

Chicken pox? Yes / No Age: _____ Mumps? Yes / No Age: _____ Whooping cough? Yes / No Age: _____

Rubeola? Yes / No Age: _____ Rubella? Yes / No Age: _____ Other: _____ Age: _____

Number of doses of antibiotics your child has taken:

During past 6 months: _____ Total during lifetime: _____ Drug names: _____

Number of doses of other prescription medications your child has taken:

During past 6 months: _____ Total during lifetime: _____ Drug names: _____

Has your child been vaccinated? Yes / No

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Kidney Disease
Father's Side:	_____	_____	_____	_____	_____
Mother's Side:	_____	_____	_____	_____	_____

Other familiar diseases: _____

Has your child ever experienced or is currently experiencing:

Past / Present		*Past / Present*		*Past / Present*	
____/_____	Ear infection	____/_____	Asthma/Allergies	____/_____	Colic
____/_____	Digestive problems	____/_____	Bed Wetting	____/_____	Seizures
____/_____	Attention Deficit Disorder	____/_____	Chronic Colds	____/_____	Scoliosis
____/_____	Growing/Spinal Pains	____/_____	Hyperactivity	____/_____	Headaches

I hereby authorize this office and it's chiropractors to administer chiropractic care to my son/daughter as they deem necessary.

Parent/Guardian Signature: _____ Date: _____