



CHILDREN'S HEALTH HISTORY – **CONFIDENTIAL** Date: _____

Child's Name: _____

Main complaint and symptoms: _____

How long has the problem been present? ___day(s) ___week(s) ___month(s) ___year(s)

This problem is getting... better worse stays the same comes & goes .

Other treatment sought for this, and results: _____

List any diagnosis already made: _____

Any school time missed due to this condition? _____

What makes the condition worse? _____

What makes the condition better? _____

Child also suffers from: _____

ACCIDENTS: List **any** significant car accidents or falls:

Date	Describe the accident Eg: fell on pavement on left hand	Injuries Eg: broke wrist	Treatment Eg: cast, hospital
1			
2			
3			

DIAGNOSTICS

Any **x rays** taken? NO If yes, complete below: _____ date: _____

Body part:	

Ever had any **blood tests**? Please list dates and results: _____

Ever had any **urine tests**? Please list dates and results:



Any surgery? Give details below:

Type	Year	Did it help?

List any major illnesses your child has had:

Is she/he allergic to anything? _____

List type and year of any fractures or dislocations: _____

Are you giving the child any of the following:

Medication _____

Nutritional supplements _____

Other _____

BIRTH AND CHILDHOOD

Were they:

A forceps delivery a long labour difficult birth caesarean vaccinated

Have they had:

Chicken pox mumps measles whooping cough other _____

FAMILY HISTORY

	GOOD	POOR	Had/Have the following significant health conditions:
MOTHER'S HEALTH			
FATHER'S HEALTH			
OTHER			

HABITS - tick if applies

Diet	Eats well ___ Eats fruit ___ Eats vegies ___
	Soft drinks per day ___ Child's diet is of concern to me ___
Sleep	Ave. hours per day ___ Sleeps on stomach <input type="checkbox"/> side <input type="checkbox"/> back ___
	Age of mattress is ___ years Has poor, irregular sleep patterns <input type="checkbox"/> .

Has been to a chiropractor before? No. Date of last visit, if yes _____

Name of the chiropractor _____ Did they help you? _____

SOCIAL HISTORY

List any activities engaged in socially, and any SPORTS:



List any activities no longer performed because of health problems:

SYSTEMS REVIEW

Please tick any conditions currently experienced NOW. Cross if ever experienced before.

Asthma	<input type="checkbox"/>	Stomach ache	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	Moody	<input type="checkbox"/>
Ear ringing	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	Nervous	<input type="checkbox"/>	Irritable	<input type="checkbox"/>
Nose blocked	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	Learning problems	<input type="checkbox"/>	Falls over a lot	<input type="checkbox"/>
Gums sore	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>
Gums bleed	<input type="checkbox"/>	Thumb sucking	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	Lumps on body	<input type="checkbox"/>
Swollen glands	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
Breast discharge	<input type="checkbox"/>	Thrush	<input type="checkbox"/>	Arm pain	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Sore muscles	<input type="checkbox"/>	Elbow pain	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	Hand pain	<input type="checkbox"/>	Chills	<input type="checkbox"/>
Flu	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	Jaw problems	<input type="checkbox"/>
Chest infections	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	FEMALE ONLY	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	Frequent worms	<input type="checkbox"/>	Foot problems	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Pain waking at night	<input type="checkbox"/>	Menstrual pain	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	Fits	<input type="checkbox"/>	Crossed eyes	<input type="checkbox"/>		<input type="checkbox"/>

Do you want to go on our E-mail list for periodic health information? No

Yes, my email is: _____

May we thank the person who referred you to this office? No Don't Know

Yes: Name of referrer _____

PLEASE SIGN BELOW,

Print Name: _____

Date: _____

Signature: _____