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:

_____

SURGERY

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☐ side☐ back____
	Age of mattress is ___ years Has poor, irregular sleep patterns☐ .

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

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: _____