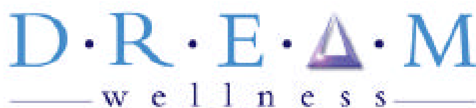

Child Health History Form

We are happy you have chosen to have your child's spine checked. Many types of stress (physical, mental, and chemical) can interfere with you child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions!

Child's Name_________________________________ Date of Birth___________ Pt. # _______

Address______________________________________ City/State________________ Zip______

Home Phone____________ Parent's work phone _______________ Parent's Cell ___________

Mother's Name__________________ Father's Name ________________________

Names and Ages of Siblings ____

Reason for consulting our office ____

Social Security # _________________________

Previous Chiropractic Care? Y/N If yes, with whom? _____________________

How long was care received? ___________ Last Check-up_______

Insured's SS# _____________ Place of Work _________________ Date of Birth ___________

Circle Appropriately

Birth Place: Home/Birth Center/Hospital

Type: Vaginal/C-section

Procedures: Forceps/Vacuum Extraction

Was delivery long: Y/N Was delivery difficult? Y/N Labor Induced? Y/N

Epidural? Y/N Pain Medication? Y/N

Was baby breech/in utero-constraint? Y/N

Was baby breast fed? Y/N Duration________

Which sports does/did your child participate in?

None/Soccer/Football/Gymnastics/Cheerleading/Karate/Basketball/Dance

Other(s) ______________________________________

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc...) during the first year of life. Has this happened to your child? Y/N Comments__________________

List any other falls or accidents____

Check any of the following conditions your child has suffered from:
(Circle ‘C’ for current, circle 'P' if in the distant past, circle 'R' if in the past 6 months)

C/P/R Ear Infections	C/P/R Scoliosis	C/P/R Seizures
C/P/R Chronic colds	C/P/R Asthma/Allergies	C/P/R Digestive Problems
C/P/R Headaches	C/P/R ADD/ADHD	C/P/R Recurring Fevers
C/P/R Growing/Back Pains	C/P/R Colic	C/P/R Bed Wetting
C/P/R Constipation	C/P/R Head Banging	C/P/R Other:___________

List date and year of any surgeries or hospitalizations ______________________

____

MEDICATION
How many rounds of antibiotics has your child taken in the last 6 months?__________
Lifetime___________

Present prescription drugs____

Past prescription drugs____

Over the counter drugs (past 6 months) ___________________________________

FINANCIAL INFORMATION
Person responsible for account: _____________________________
Are you planning to use some type of insurance? Y/N

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AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize DREAM Wellness and whomever they may designate to administer care, as they deem necessary to my son/daughter.
May presence is / is not necessary for care to be rendered (circle one).

Signed:______________________________

Today’s Date: _________________________