Health History 4 Kids

Name: _____ Birthday: _____ Age: ____ Today's Date: _____

Address: _____ City & State:_____ Zip: _____

Parent/Guardian Name:_____ Phone:_____Email:_____

Male____ Female____ School:_____ Number of Siblings: _____

Birth: Home: _____ Hospital: _____ Birth Center: _____ Other: _____ Complications? Y / N _____

Whom may we thank for referring you to our office? _____ Visited Chiropractor Before? Y / N

Vaccination Status: Regular Schedule _____ Alternate Schedule _____ Unvaccinated _____

Would you like more information on vaccination and making an informed decision for your child? Y / N

Your Health Summary

Past	Current		Past	Current		Past	Current	
☐	☐	Headaches	☐	☐	Asthma	☐	☐	Stomach Upset
☐	☐	Migraines	☐	☐	Constipation	☐	☐	Emotional Trauma
☐	☐	Dizziness	☐	☐	Light sensitivity	☐	☐	Sports Injury
☐	☐	Frequent Infections	☐	☐	Vaccine Injury	☐	☐	Auto Accident
☐	☐	Ear Infections	☐	☐	Sinus Infections	☐	☐	Weight Trouble
☐	☐	Sleeping problems	☐	☐	Fainting	☐	☐	Heartburn
☐	☐	Diarrhea	☐	☐	Back pain	☐	☐	Auto-Immune
☐	☐	Cold Sweats	☐	☐	Ringing in ears	☐	☐	Anxiety
☐	☐	Mood swings	☐	☐	Irritability	☐	☐	Diabetes
☐	☐	Behavioral Problems	☐	☐	Cold Hands/Feet	☐	☐	Gas
☐	☐	ADD/ADHD	☐	☐	Fever	☐	☐	LearningDisability
☐	☐	Autism	☐	☐	Problems urinating	Other:_____		
☐	☐	Asperger's	☐	☐	Neck pain	_____		
☐	☐	Allergies	☐	☐	Loss of balance	_____		

List any medications: _____

On a scale of 1-10 with 10 being perfect health, my child's health today is a _____/10. I would like it to be a _____/10.

Is there anything else you would like to inform the doctor about?

_____

_____

_____

_____

_____

_____

Media: Some parts of your visits made monitored with photography, video, or audio recording. Please initial to indicate that you have been made aware.

_____ (Please Initial)