

Child Health Form

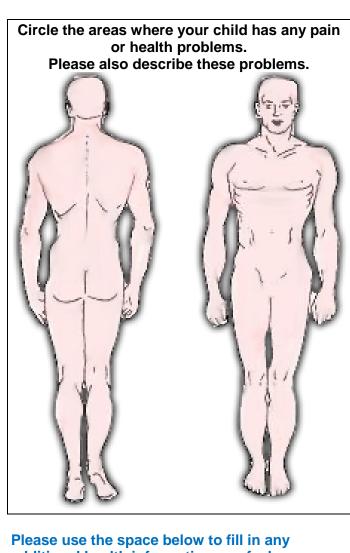
To be filled out by parent or guardian. Please print clearly and fill in completely.

Print Child's Name		Date of Birth			
Street Address			Apt.#		
City	State	Zip	Phone		
Please Check ✓ Sex: M	ale □ Female □ F	Right handed	d□ Left handed□		
Health History: Give reason for seeking ch	niropractic care:				_
Describe any health proble	ems, including how	long you've	had them:		_
Is the child under the care	of any other docto	r? Yes □ N	o□ If Yes, explain co	nditions being treated for:	_
List any current Medication	าร:				_
List any past surgeries & c	lates:				_
List any past accidents & c	dates:				_
List any x-rays you've had					_
Chiropractic History: Have you ever been to a C			□ If yes, Doctor's Nar	ne	
Date of last chiropractic vis	sit	Reas	on for care		
Date of last chiropractic x-	rays	How	long were you under ca	are?	
Are other family members	under chiropractic	care? - Yes	□ No□ Who?		
members. To better help Based on a scale of 10% t	are dedicated toward you achieve this of 100%, please cire-30%40%	; we need to	o understand how you u feel is your current le	ng health for each of our pract view your child's overall heavel of health and wellness.	lth.
Please describe any other he	alth history informatio	on you feel wo			-
I authorize examination and c	are for the minor liste	ed above as I	am this child's parent or le	egai guardian.	
Print Parent's Name:_				_	
Parent's Signature: Please continue on the				_Date:	-

Please Fill in Below Has you child currently or recently suffered from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headaches		
Migraines		
Neck Pain		
Shoulder Pain		
Arm/Hand Pain		
Mid Back Pain		
Low Back Pain		
Hip Pain		
Leg/Foot Pain		
Muscle pain		
Growing pains		
Other joint pain		
Numbness		
Joint Swelling		
Dizziness		
Nausea		
Weakness		
Fatigue		
Nervousness		
Insomnia		
Ear infections		
Earaches		
Nose Bleeds		
Ringing in Ears		
Frequent colds		
Hearing Loss		
Cough		
Chest pains		
Asthma		
Allergies		
ADHD		
Hyperactivity		
Hypoglycemia		
Diabetes		
Eating Disorders		
Digestive problem		
Skin conditions		
Learning Disabilities		

Please make sure you have signed and dated side one of this form.



Please use the space below to fill in any additional health information you feel we may need for your child's care.				