

MOUNTAIN VALLEY FAMILY CHIROPRACTIC CHILD'S HEALTH HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name _____ Today's Date ____/____/____ PtID#: _____

Date of Birth ____/____/____ Age: ____ Current Height: ____ Current Weight: ____

Address _____ City _____ State _____ Zip _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Phone # _____

Who is responsible for this bill? Father Social Security # _____ - _____ - _____ Mother Social Security # _____ - _____ - _____

Other (please explain): _____



Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the Issues That Brought You to the Office

Purpose of this visit: _____ Wellness Check-up _____ Injury or Accident _____ Other Please explain: _____

If your child is experiencing *pain/discomfort please identify where* _____ *and for how long* _____

If he/she is experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant

Since the problem started, is it: Getting Better Getting Worse About the Same

The problem interferes with: School Sleep Walking Sitting Hobbies Other: _____

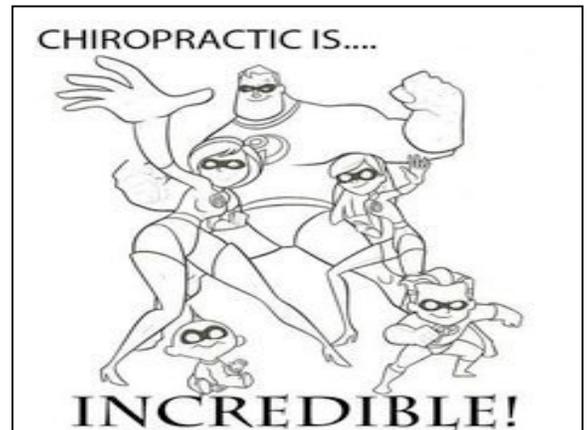
Other Doctors seen for this problem:

Chiropractor: _____

Medical Doctor: _____

Other: _____

List medications the child is taking or surgeries the child has had:



HAS YOUR CHILD EVER SUFFERED FROM: mark **Y** for YES OR **N** for NO

- | | | | | |
|-------------------------|-------------------------|--------------------------|-------------------------|--------------------------------|
| ___ Headaches | ___ Orthopedic Problems | ___ Digestive Disorders | ___ Behavioral Problems | ___ Fall From Changing Table |
| ___ Neck Problems | ___ Poor Appetite | ___ ADD/ADHD | ___ Fainting | ___ Fall Off Skateboard/Skates |
| ___ Stomach Aches | ___ Ruptures/Hernia | ___ Seizures/Convulsions | ___ Leg Problems | ___ Fall From Bed or Couch |
| ___ Muscle Pain | ___ Heart Trouble | ___ Joint Problems | ___ Constipation | ___ Fall Off Monkey Bars |
| ___ Chronic Earaches | ___ Backaches | ___ Diarrhea | ___ Sinus Trouble | ___ Fall From High Chair |
| ___ Hypertension | ___ Asthma | ___ Scoliosis | ___ Anemia | ___ Arm Problems |
| ___ Walking Trouble | ___ Bed Wetting | ___ Colic | ___ Broken Bones | ___ Dizziness |
| ___ Fall In Baby Walker | ___ Fall From Crib | ___ Fall Off Swing | ___ Fall Off Bicycle | ___ Growing Pains |
| ___ Fall Downstairs | ___ Fall Off Slide | ___ Sleeping Problems | ___ Colds/Flu | ___ Poor Posture |
| ___ Reflux | Allergies to _____ | Other: _____ | | |

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was mom on any medications, prescriptions, or over-the-counter? Yes No

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? Yes No

Was the baby ever in the Breech position? Yes No

How many ultrasounds performed? _____

Birth and Delivery:

Where was the baby born? Home Hospital Birthing Center Other: _____

Was the delivery: Vaginal C-Section Were any devices used? Forceps Vacuum

How long was labor? _____ How long was the delivery? _____

Was oxytocin / pitocin used? Yes No Was an epidural administered? Yes No

Infancy:

Was the infant vaccinated? Yes No If yes, any reactions/changes after? _____

Was there any prolonged use of medicines or an inhaler? Yes No If yes, which? _____

Did the infant suffer any traumas such as serious falls or car accidents? Yes No

Childhood Years:

Did the child have any childhood illnesses? Yes No Explain: _____

Did the child play youth sports? Yes No Which Sport? _____

Has the child had any surgery? Yes No Explain: _____

Has the child fallen from a height over 3 feet? Yes No Explain: _____

Was the child involved in any car accidents? Yes No Explain: _____

Has there been any prolonged use of medications? Yes No Explain: _____

Has the child suffered emotional traumas? Yes No Explain: _____

Please provide us any other health information you feel would be helpful: _____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature: _____

Date: _____