



## Child's Health History Form

Natural Potential Chiropractic Clinic

**Why Is this form Important?** As a family chiropractic office we focus on your child's ability to be healthy. We would first like to address the issues that brought you in to our office and later would like to offer you and your child the opportunity of improved health and wellness.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ SSN \_\_\_\_\_

Birth Date \_\_\_\_\_ Male or Female \_\_\_\_\_

Reason For Consulting Office \_\_\_\_\_

Whom may we thank for referring you \_\_\_\_\_

### Present Health Challenge

If your child does not currently have a health challenge please indicate here with an "X" \_\_\_\_\_

If you child DOES currently have a health challenge please provide a brief history of the issue including the effect it is having on the child \_\_\_\_\_

Circle One:

If your child is experiencing pain is it: Sharp Dull Comes and Goes Travels Constant

Since the issue started is it: About the Same Getting Better Getting Worse

What makes it worse: \_\_\_\_\_

Is it interfering with: School Sleep Walking Sitting Hobbies Other \_\_\_\_\_

Other Health Care Professionals Seen for this problem:

Chiropractor: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Other: \_\_\_\_\_

Please List Medications Child is taking or Surgeries the Child Has Had:

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Daily we experience physical, chemical, and emotional stresses that can accumulate and result in a serious loss of health potential. Most times the effects are gradual and begin 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? \_\_\_\_\_

If yes please explain \_\_\_\_\_

Did mom or dad smoke during the pregnancy? \_\_\_\_\_ If so, who? \_\_\_\_\_

Was the baby ever in breech presentation? \_\_\_\_\_

How many ultrasounds were performed? \_\_\_\_\_

### Birth and Delivery

Where was the baby born? (Circle one) Home Hospital Birthing Center Other \_\_\_\_\_

Was the delivery? Vaginal C-section Were there any devices used? No Forceps Vacuum

How long was the labor? \_\_\_\_\_ How long was the delivery? \_\_\_\_\_

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

## Infancy

Was the child vaccinated? \_\_\_\_\_ Were there any prolonged use of medications or an inhaler?  
\_\_\_\_\_ If yes which? \_\_\_\_\_

Did the infant suffer any traumas such as serious falls or accidents? \_\_\_\_\_

Has the infant been under regular chiropractic care? \_\_\_\_\_

## Childhood Years

Did the child have any childhood illnesses? \_\_\_\_\_ If yes, which? \_\_\_\_\_

Does the child play sports? \_\_\_\_\_ If yes, which? \_\_\_\_\_

Has the child had surgery? \_\_\_\_\_ If so, why? \_\_\_\_\_

Has the child fallen from a height over 3ft? \_\_\_\_\_ Where? When? \_\_\_\_\_

Was the child involved in any car accidents? \_\_\_\_\_ Explain \_\_\_\_\_

Has there been any prolonged use of meds? \_\_\_\_\_ Explain \_\_\_\_\_

Has the child suffered any emotional traumas? \_\_\_\_\_ Explain \_\_\_\_\_

Please provide any other information that may be helpful \_\_\_\_\_

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**I acknowledge that the statements in 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** \_\_\_\_\_