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:

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_____

_____

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_____