

Child's Name: _____ Name the child prefers to be called: _____

Name of Mom, Dad, or guardian: _____

Address: _____ DOB: _____ Age: _____ Gender: M F

City: _____ State: _____ Zip: _____ Home #: _____ Cell #: _____

SS#: _____ - _____ - _____ Family E-mail: _____

Best place to reach you: Home Cell Work: () _____ ext: _____

Children's Siblings and ages (if applicable): _____

Who is your child's primary care doctor? _____
(Please list the name of your child's doctor and the facility)

May we contact him or her about your care? Y N Were you referred by him or her? Y or N

Insurance Information

Are your child's symptoms related to an accident? Y N Automobile Work Other Date: ____/____/____

Current Complaints

Major complaints and symptoms: 1) _____
 2) _____
 3) _____

How do you believe the child's problem or pain began? _____

Has your child seen any provider for this condition?




What did they do, and did it help?

1. _____

_____ Y N

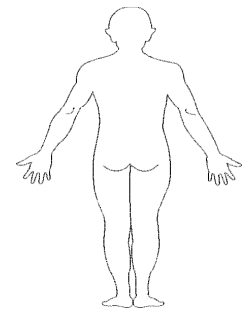
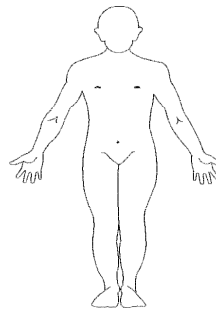
2. _____

_____ Y N

<p>On a Scale of 0—10, I rate my discomfort as follows: (zero being no pain, 10 being the worst pain I have ever felt)</p> <p>Neck-Shoulder-Arm Pain</p>  <p>Mid Back Pain</p>  <p>Low Back- Leg Pain</p> 	<p>Vitamins and Supplements</p> _____ _____ _____ _____	<p>Allergies</p> _____ _____ _____
	<p>Medications (please write additional on separate sheet of paper)</p> _____ _____ _____	

SHOW AREA(S) OF PAIN OR SYMPTOMS

Mark the areas on this body where your child feels pain or symptoms.



TRAUMA (if answer is yes– please list the approximate age of occurrence)

Has your child had any recent falls or injuries? N Y: _____

Has your child ever fallen downstairs or fallen from any height? N Y: _____

Has your child ever been in a motor vehicle collision? N Y: _____

Has your child ever had a bone fracture or joint dislocation? N Y: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades, or similar? N Y: _____

Has your child had any other trauma or injuries? N Y: _____

NUTRITION (if answer is yes– please describe)

Do you have any concerns about your child’s diet? N Y: _____

Does your child take vitamin supplements? N Y (see front section of listed supplements)

Does your child eliminate stools each day? N Y if no, how often? _____

How many glasses of water does your child drink each day? _____

How many cans of soda does your child drink each day? _____ Or, per week? _____

How much cow’s milk does your child drink each day? _____

Does your child eat fruits and vegetables? N Y _____

GROWTH and HEALTH HISTORY (if the answer is yes, please describe briefly)

Was your child born premature? N Y If yes, at what month / week was your child born? _____

Does your child ever complain of neck or back pain? N Y: _____

Does your child ever complain of pain in his/her arms or legs? N Y: _____

Does your child ever complain of headaches? N Y: _____

Does your child have a problem with bedwetting (if potty-trained)? N Y: _____

Does your child have excessive belching or passing gas? N Y: _____

Does your child have any known food allergies? N Y (See the front box listed Allergies)

Does your child have frequent or occasional skin rashes? N Y: _____

Has your child ever had an upper respiratory infection? N Y If yes, at what age(s): _____

Has your child had asthma? N Y If yes, what age was it diagnosed? _____

Does your child have frequent earaches? N Y If yes, when did they start? _____

Has your child had any other significant illnesses? N Y: Chickenpox Strep Throat RSV bronchitis pneumonia

Has your child taken antibiotics? N Y If yes, how many treatments? _____

Is your child presently on any medications? N Y (See front box of listed medications)

Has your child been recently vaccinated? N Y Has your child been following the vaccination schedule? N Y

Has your child previously had chiropractic care? N Y If yes, date of last treatment? _____

Do you have any other concerns about your child’s health? _____