MountainValley
CHIROPRACTIC

Child Health History

(Ages 2-12)

Name: _____ DOB: _____ Date: _____

Parent(s)/Guardian(s) Name(s): _____ Enrolled in Traditional Medicare? ☐ Yes ☐ No

Chief Complaint: _____

How and when did it start? _____

What makes it better? _____ What makes it worse? _____

Has your child been treated for this condition before? ☐ Yes ☐ No If yes, by whom? _____

Is your child currently under a healthcare provider's care for any other problems? ☐ Yes ☐ No

Previous Chiropractic Care: Last visit? Reason? Duration of care? _____

_____

Current Medications/Antibiotics/Supplements: _____

_____

Past Medications/Antibiotics: _____

_____

Hospital/ER Visits/Surgeries? _____

_____

Other Injuries/Accidents: _____

_____

Prenatal History

Complications During Pregnancy: (circle, if any)

Toxemia Diabetes Morning Sickness Heartburn Back Pain Headaches Other

Mother's Health/Nutrition: (circle one) Poor Good Excellent

Stress During Pregnancy: (rate 1-10) ____ Falls/Injuries/Accidents During Pregnancy: _____

Family History of: (circle, if any) Diabetes Heart/Cardio Problems Other _____

Complications During Delivery: (circle)

None C-Section Vacuum/Forceps Induced Epidural Fetal Distress Meconium Oxygen ICU

Birth Injuries: (list) _____

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Rate the Following:

	Poor		Average		Exceptional
General Health	O	O	O	O	O
Overall Diet	O	O	O	O	O
Exercise Routine	O	O	O	O	O
Overall Stress	O	O	O	O	O

What **Physical Stresses/Injuries** has your child experienced (Sports Injuries, Poor Posture, etc.)? _____

_____

E**motional Stresses** (Fear, Family, Temper, etc.)? _____

_____

Chemical Stresses (Second Hand Smoke, Sugar, etc.)? _____

_____

Vaccines: (circle)

Y N Partial Complete

Reactions, if any: (fever, fussy, etc.)

Slight Mild Severe

Describe reactions: _____

Check any of the following that your child has suffered from:

- ☐ Allergies
- ☐ Asthma
- ☐ Attention/Hyperactivity
- ☐ Bedwetting
- ☐ Digestive Difficulties
- ☐ Ear Infections
- ☐ Foot/Hip/Leg Problems
- ☐ Head Banging or Headaches
- ☐ Heart Conditions
- ☐ Seizures
- ☐ Sleep Problems
- ☐ Spitting Up/Vomiting
- ☐ Vision Problems

Patient Name: _____ Signature: _____ Date: ___/___/___

Parent or Guardian: _____Signature: _____ Date: ___/___/___