

Kids Health History and Family Information

Patients Name: _____ Today's date _____
last first middle

Address _____
street city postal code

Gender M F Date of Birth _____ Age _____

Name of Parents / Guardians _____

Home Phone _____ Work number _____ Cell Phone _____

Medical Doctor _____

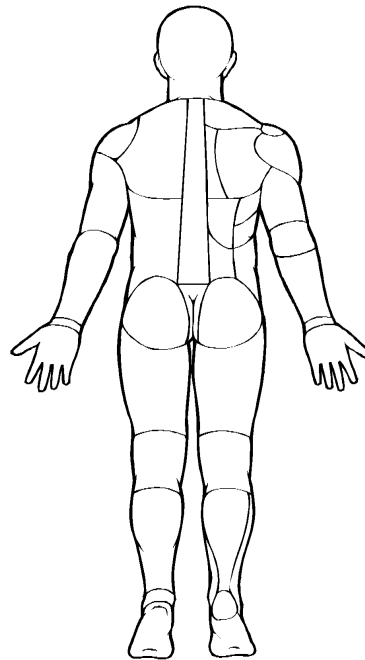
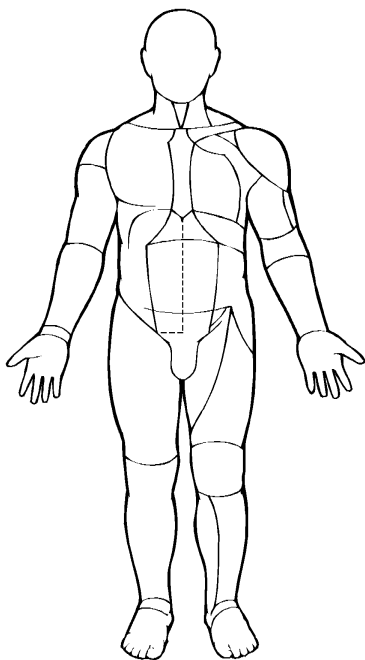
Do you need receipts for extended health insurance? _____ ICBC? _____

How did you hear of our office? _____

Previous Chiropractic care? Y / N Whom? _____

When? _____

If there are any areas of concern please indicate them below



Check any of the following conditions your child has suffered from over the past six months:

Scoliosis	Ear Infections	Seizures	Growing Pains	Asthma / Allergies
ADHD	Car Accident	Headaches	Recurring Fevers	Digestive Problems
Colic	Bed Wetting	Chronic Colds	Temper Tantrums	Other _____

Family History _____

Number of doses of Antibiotics your child has taken _____

Other Medication your child has taken _____

Vaccination History _____

Prenatal History:

Complications during pregnancy? Y / N _____

Complications during delivery? Y / N _____

Birth weight _____

Genetic disorders or disabilities: _____

Feeding History:

Breast Fed? Y / N How long? _____

Food / Juice allergies? Y / N List: _____

Developmental History:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie. a bed, changing table, down stairs, etc.). Was this the case with your child? Y / N When? _____

Is / has your child been involved in any high impact or contact type sports (ie. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y / N List: _____

Has your child ever been in a car accident? Y / N When? _____

Any other traumas or surgeries? Y / N List: _____

Childhood Diseases:

Chicken Pox	Y / N	Age	_____	Mumps	Y / N	Age	_____
Rubella	Y / N	Age	_____	Whooping Cough	Y / N	Age	_____
Rubeola	Y / N	Age	_____	Other	Y / N	Age	_____

Have we missed anything? _____
