MOUNTAIN VALLEY FAMILY CHIROPRACTIC CHILD'S HEALTH HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name_____ Today's Date _____/_____/____ PtID#:_____

Date of Birth _____/_____/_____ Age: _____ Current Height: _____ Current Weight: _____

Address _____ City _____ State _____ Zip _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

Phone # _____

Who is responsible for this bill? ❑ Father Social Security # _____-_____-_____ ❑ Mother Social Security # _____-_____-_____

❑ Other *(please explain):*

Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the Issues That Brought You to the Office

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other Please explain:_____

If your child is experiencing ***pain/discomfort please identify where*** _____***and for how long*** _____

If he/she is experiencing pain, is it: ❑ Sharp ❑ Dull ❑ Comes and Goes ❑ Travels ❑ Constant

Since the problem started, is it: ❑ Getting Better ❑ Getting Worse ❑ About the Same

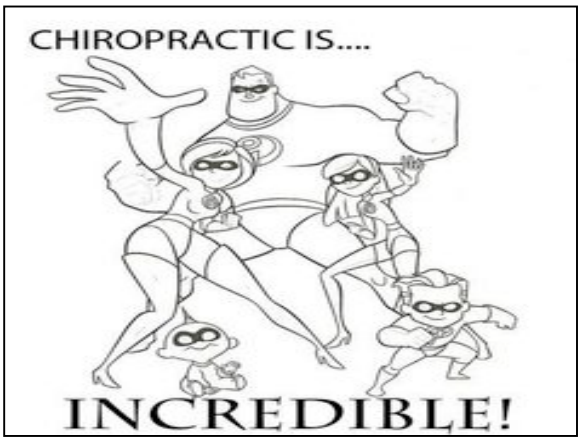
The problem interferes with: ❑ School ❑ Sleep ❑ Walking ❑ Sitting ❑ Hobbies ❑ Other:_____

Other Doctors seen for this problem:

Chiropractor: _____

Medical Doctor: _____

Other: _____



List medications the child is taking or surgeries the child has had:

_____

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: mark **Y** for YES OR **N** for NO

___Headaches	___Orthopedic Problems	___Digestive Disorders	___Behavioral Problems	___Fall From Changing Table
___Neck Problems	___Poor Appetite	___ADD/ADHD	___Fainting	___Fall Off Skateboard/Skates
___Stomach Aches	___Ruptures/Hernia	___Seizures/Convulsions	___Leg Problems	___Fall From Bed or Couch
___Muscle Pain	___Heart Trouble	___Joint Problems	___Constipation	___Fall Off Monkey Bars
___Chronic Earaches	___Backaches	___Diarrhea	___Sinus Trouble	___Fall From High Chair
___Hypertension	___Asthma	___Scoliosis	___Anemia	___Arm Problems
___Walking Trouble	___Bed Wetting	___Colic	___Broken Bones	___Dizziness
___Fall In Baby Walker	___Fall From Crib	___Fall Off Swing	___Fall Off Bicycle	___Growing Pains
___Fall Downstairs	___Fall Off Slide	___Sleeping Problems	___Colds/Flu	___Poor Posture
___Reflux	Allergies to_____		Other: _____	

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very 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? ❑ Yes ❑ No

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? ❑ Yes ❑ No

Was the baby ever in the Breech position? ❑ Yes ❑ No

How many ultrasounds performed? _____

Birth and Delivery:

Where was the baby born? ❑ Home ❑ Hospital ❑ Birthing Center ❑ Other: _____

Was the delivery: ❑ Vaginal ❑ C-Section Were any devices used? ❑ Forceps ❑ Vacuum

How long was labor? _____ How long was the delivery? _____

Was oxytocin / pitocin used? ❑ Yes ❑ No Was an epidural administered? ❑ Yes ❑ No

Infancy:

Was the infant vaccinated? ❑ Yes ❑ No If yes, any reactions/changes after? _____

Was there any prolonged use of medicines or an inhaler? ❑ Yes ❑ No If yes, which? _____

Did the infant suffer any traumas such as serious falls or car accidents? ❑ Yes ❑ No

Childhood Years:

Did the child have any childhood illnesses? ❑ Yes ❑ No Explain: _____

Did the child play youth sports? ❑ Yes ❑ No Which Sport? _____

Has the child had any surgery? ❑ Yes ❑ No Explain: _____

Has the child fallen from a height over 3 feet? ❑ Yes ❑ No Explain: _____

Was the child involved in any car accidents? ❑ Yes ❑ No Explain: _____

Has there been any prolonged use of medications? ❑ Yes ❑ No Explain: _____

Has the child suffered emotional traumas? ❑ Yes ❑ No Explain: _____

Please provide us any other health information you feel would be helpful: _____

_____

The statements made on 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:** _____