GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo._____ Total during lifetime_____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit _____/_____/_____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home
7. Complications During Pregnancy: ❑ No ❑ Yes Explain: _____
8. Ultrasounds During Pregnancy: ❑ No ❑ Yes How Many: _____
9. Medication During Pregnancy / Delivery ❑ No ❑ Yes List: _____
10. Cigarette / Alcohol Use during Pregnancy: ❑ No ❑ Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": ❑ No ❑ Yes, Name_____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____
_____
16. Please list any past hospitalizations and surgeries: _____
_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Is there any other family history you want us to know?_____