Chiropractic First

Child Health History Form

Child's Name: _____ Date:_____

Date of Birth: _____ Age: _____ ☐ Female ☐Male
Height:_____ Weight: _____lbs.
Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Cell: _____ Work:_____

Would you like to be added to our mailing list to receive our monthly newsletter? ☐ Yes ☐ No

E-mail: _____

Which is your preferred contact? Please indicate which phone number or email: _____

Insurance Provider: _____

How did you hear about Dr. Meggie Smith or Chiropractic First? _____

Why is your child seeking care in the office? ☐ To experience a new degree of health and healing
☐ To get rid of pain
☐ To be more connected with body and self
☐ Don't know
☐ Other: _____

Has your child had chiropractic care in the past? ☐ Yes ☐ No
Did you find it helpful? ☐ Yes ☐ No
What are the main concerns or goals for your child's chiropractic care?_____
_____

Have you consulted any other health care practitioners about these concerns? ☐ Yes ☐ No
If yes, Who: _____
What was done: _____

Name: _____

Is your child taking any medications? ☐ Yes ☐ No If yes, please list and include any over the counter medication.

The Pregnancy Process

During the pregnancy process, did the mother:

□ Take medications. Please list: _____

□ Smoke or Consume Alcohol or Drugs. Please list: _____

□ Experience any illness. Please list: _____

□ Undergo a lot of stress

□ Receive ultrasounds or radiation. Dates: _____

Birthplace: □ Home □ Hospital □ Birthing Center □Other

Type of Birth: □ Vaginal □ C-Section

Position: □ Cephalic (head first) □ Breech □ Occiput Posterior (facing forward)

Procedures: □ Forceps □ Vacuum Extraction

Birth Assistants: □ M.D. □ Midwife □ Doula

Did the person assisting the delivery twist or pull the baby during the delivery? ☐ Yes ☐ No

How long did labor and delivery last? _____

What was the mother's position during labor? □ Back □ Side □ Sitting □ Standing

□ Other: _____

Did the mother have an episiotomy? ☐ Yes ☐ No

Was the labor chemically induced? ☐ Yes ☐ No

What was the child's gestational age at birth? _____

Were any drugs administered during the labor process (IV or epidural)? ☐ Yes ☐ No

Vaccinations

Have you chosen to vaccinate your child? ☐ Yes ☐ No

If yes, check all vaccinations received:

☐ DPT ☐ MMR ☐ Polio

☐ Chicken Pox ☐ Hepatitis ☐ Flu

☐ Other: _____

Name: _____

Describe any reactions to the vaccine(s): _____
_____

General Health

Has your child's body expressed any of the following:

- ☐ Vision Problems
- ☐ Headaches
- ☐ Sleeping Difficulty
- ☐ Irritability
- ☐ Frequent Colds
- ☐ Digestive Problems
- ☐ Other: _____
- ☐ Sensory Processing
- ☐ Ear Problems
- ☐ Tubes in the Ear
- ☐ Attention Problems
- ☐ Bedwetting
- ☐ Hyperactivity
- ☐ Constipation
- ☐ Asthma
- ☐ Colic
- ☐ Skin Problems
- ☐ Breathing Problems
- ☐ Allergies: _____ _____

Is your child accident prone? ☐ Yes ☐ No

Do you feel that your child's social and emotional development is normal for their age? _____
_____

Any night terrors, sleep walking, or difficulty sleeping? ☐ Yes ☐ No If yes: _____
_____

Has your child:

- ☐ Been hospitalized/surgery? _____
- ☐ Had a severe fall? _____
- ☐ Been in a car accident? _____
- ☐ Had traumas resulting in bruises, fractures or stitches? _____

Does your child participate in sports or physical extracurricular activities (i.e. dance)?

☐ Yes ☐ No If yes, please list activity and date started: _____

Approximate hours a week: _____

Does your child consume:

- ☐ Caffeine
- ☐ Artificial Sweetener
- ☐ Soda
- ☐ Fast Food
- ☐ Sugar
- ☐ Processed Foods

Would you like to see any changes in your child's health or behavior?

_____
_____

What additional health care resources are you utilizing (i.e. massage, nutrition, acupuncture)?

_____
_____