



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: _____

E-mail: _____

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

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

Insurance Provider: _____ Insured's DOB: ____/____/____

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: _____
- 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

Check all vaccinations received:

- DPT
- Chicken Pox
- None
- MMR
- Hepatitis
- Other: _____
- Polio
- Flu

Describe any reactions to the vaccine(s): _____

Name: _____

General Health

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Sensory Processing | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sleeping Difficulty | <input type="checkbox"/> Tubes in the Ear | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Other: _____ | | _____ |

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:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Soda | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Artificial Sweetener | <input type="checkbox"/> Fast Food | <input type="checkbox"/> 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)?

