BalanceChiropractic

Preschool Child History
2 years to 5 years

Today's Date _____

Child's Name _____ Sex: ☐M ☐F Date of Birth _____ Age ___

Reason for Today's Visit _____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur? _____

Was the onset ☐ Sudden ☐ Gradual Is the problem ☐ Constant ☐ Intermittent

☐ ☐ Has your child ever had this problem before?_____

☐ ☐ Has your child previously been treated for this problem? By whom? _____

☐ ☐ Has your child previously had chiropractic care? Previous chiropractor _____

HEALTH HISTORY

Yes No

☐ ☐ Does your child ever complain of back or neck pain? _____

☐ ☐ Does your child ever complain of pains in the legs or arms? _____

☐ ☐ Does your child ever complain of headaches? _____

☐ ☐ Has your child had asthma? _____

☐ ☐ Is your child allergic to anything? _____

☐ ☐ Are there any smokers in the child's home? _____

☐ ☐ Has your child had any earaches? At what age did the child's first earache occur? ___

How frequently does your child have earaches? _____

In which ear do your child's earaches usually occur? ☐ Right ☐ Left ☐ Both

☐ ☐ Is your child presently taking any prescribed medication? _____

Please list any other illness which have been a concern for your child _____

_____

Please list any surgeries your child has had _____

_____

☐ ☐ Do you have any other concerns about your child's health? _____

_____

BalanceChiropractic

TRAUMA

Yes No

☐ ☐ Has your child had any recent falls or trauma? Describe the trauma and the date it occurred. _____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____

☐ ☐ Has your child ever fallen down stairs or from a significant height? _____

☐ ☐ Has your child ever been in a motor vehicle collision or a near-miss? _____

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

☐ ☐ Has your child had any other trauma or injuries? _____

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed, or other object? _____

NUTRITION

Yes No

☐ ☐ Do you have any concerns about your child's diet? _____

☐ ☐ Does your child have any food allergies? _____

☐ ☐ Does your child have any persistent or intermittently occurring skin rashes? _____

☐ ☐ Does your child take vitamin supplements? _____

☐ ☐ Does your child eliminate stools each day? _____

For how many months was your child breast-fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What type of fat foods does your child like to eat? _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I herby authorize this office and its doctors to examine and administer care to my son / daughter named_____ as the examining / treating doctor deems necessary.
I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name _____ Signature _____
Date _____ Witnessed by _____

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____