Youth Health history form

Patient Information:

Date:___________________________

Childs Name:____ Date of birth: ____/_____/_____

Parent/Guardian Name:______________________________________ Relation to child:_________________

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Medical History:

Pediatrician/Family MD:____

Has your child been vaccinated? Yes______ No______ Are they up to date? Yes_____ No______

Does your child take any medications/vitamins? Yes_____ No_____

If yes, please list____

Has your child ever had chiropractic care? Yes_____ No____ If yes, when ___________________________________

Reason for previous chiropractic care____

Has your child ever had any surgeries ? Yes_____ No_____ If yes, when/what______________________________

Child's Health History:

Please indicate each of the following that your child has now or in the past had:

___Allergies	___Asthma	___Neck pain	___ Mid-Back pain	___ADHD	___Sinus problems
___Headaches	___Low back pain	___Arm/Leg pain	___Frequents colds	___Dizziness	___Sleeping issues
___Colic	___Ear Infections	___Falls/Injury	___Sports Injuries	___Fevers	___Scoliosis
___Diarrhea	___Constipation	___Poor eating	___Stomach issues	___Fractures	___Car accident

Daily Habits and Activities:

Does your child participate in any of the following (please circle)

Soccer	*Football*	*Gymnastics*	*Karate*	*Hockey*	*Lacrosse*	*Basketball*
Wrestling	*Baseball*	*Softball*	*Tennis*	*Dance*	*Volleyball*	*Swimming*

*Other sport/activities:*____

Reason for this visit?_______________________________________ **When did it begin?**______________________________

Please describe the pain:

___**dull** ___**sharp** ___**achy** ___**stiff**

___**numb** ___**burning** ___**tingling** ___**tight**

___**stabbing** ___**shooting** ___**radiating**

How often are the symptoms:

___**constantly (76-100%)** ___**frequently(51-75%)**

___**occasionally (25-50%)** ___**intermittent (25% or less)**

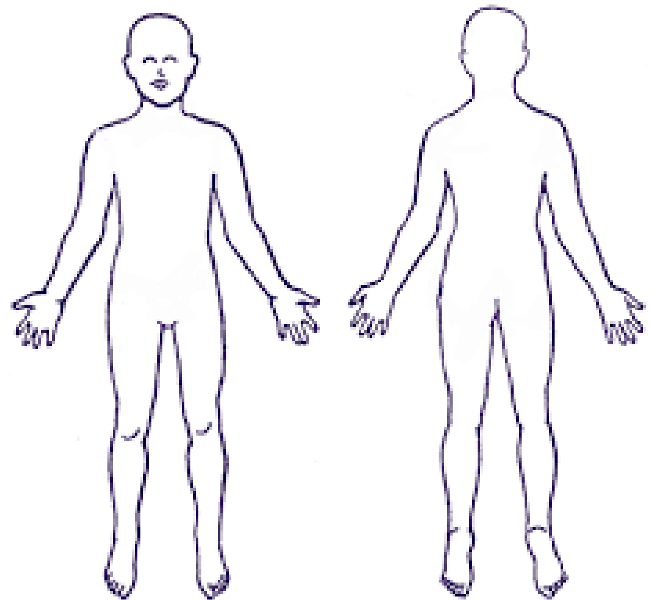
___**coming/going (with certain actions/ movements)**

Are the symptoms changing?

____**Better** ____**No Change** _____**Getting worse**

For how long? ________________________________

Please circle areas of complaint(s)



Has the child had these symptoms before? **Yes / No**

If yes when___________________________________

Please grade your symptoms:

(0=no pain) (10=severe pain)

0 1 2 3 4 5 6 7 8 9 10

Is there anything that aggravates the condition ? (Please Circle)

Bending / Lifting / Twisting / Pushing / Pulling / Sitting

Standing / Exercise / Sleeping / Computer / Video games

*Other*____

Is there anything that relieves the condition? (Please Circle)

Icing / Heating pad / Resting / Lying down / Medications

Sitting / Standing / Exercise / Bio-freeze / Icy hot gel

Other____

Child's name:____ Relation to child:___________________________

Parent/Guardian's name:____ Date:_____________________________________

Parent/Guardian's signature: _______________________________________