HOLLIS FAMILY
CHIROPRACTIC

Child Health History Form

4 Market Place, Hollis, NH 03049
p: 603.465.2235 f: 603.465.2236

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____Date of Birth: _____ Age: _____ Gender: Male Female

Phone: (H)_____ (C) _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Father's Name: _____

Parent's Marital Status: Married Single Divorced Widowed

List Ages of Other Children in Family : _____

_____

Who may we thank for referring you to our office? _____

How would you like appointment reminders sent: [ ] email [ ] text: cell provider _____

Health Profile

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you to the office:

If your child has no symptoms or complaints, and is here for ***wellness services***, please check ☐

Otherwise briefly describe the chief area of complaint, including the effect it has on the child:
_____
_____

If he/she is experiencing pain, is it: ☐ sharp ☐ dull ☐ comes & goes ☐ travels ☐ constant

Since the problem started, is it: ☐ about the same ☐ getting better ☐ getting worse?

What makes it worse? _____

It interferes with: ☐ school ☐ sleep ☐ walking ☐ sitting ☐ hobbies ☐ other: _____

Other doctors seen for this problem:
Chiropractor: _____
Medical doctor: _____
Other: _____

Date: _____ **Child's Name:** _____

List medications the child is taking or surgeries the child has had:
_____
_____
_____

Daily we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges that have influenced your child's health potential.

Pregnancy:

Was Mom on any medications, prescriptions or over-the-counter? ☐ Yes ☐ No

If yes, please explain: _____

Did Mom or Dad smoke during pregnancy? ☐ Yes ☐ No Who? _____

Did Mom drink alcohol during pregnancy? ☐ Yes ☐ No How Many? _____

Was the baby ever in Breech position? ☐ Yes ☐ No

How many ultrasounds were performed? _____

Were any fertility treatments used? ☐ Yes ☐ No

If so, please describe _____

Name of Midwife or Gynecologist: _____

During your pregnancy, did you experience any of the following? If yes, please describe.

Falls Yes No _____

Motor Vehicle Accidents Yes No _____

High Blood Pressure Yes No _____

Anemia Yes No _____

Diabetes Yes No _____

Indigestion Yes No _____

Morning Sickness Yes No _____

Swollen Ankles Yes No _____

Seizures Yes No _____

Thyroid Problems Yes No _____

Heart Problems Yes No _____

Bleeding Issues Yes No _____

Back Pain Yes No _____

Any Other Issues Yes No _____

Any Hospitalizations Yes No _____

Birth and Delivery:

Where was the baby born? ☐ home ☐ hospital ☐ birthing center ☐ other: _____

Was the delivery: ☐ vaginal ☐ c-section Were there any devices used? ☐ forceps ☐ vacuum

How long was the labor? _____ How long was the delivery? _____

Was oxytocin/pitocin used? ☐ Yes ☐ No Was an epidural administered? ☐ Yes ☐ No

Birth weight: _____ Current weight: _____

Additional comments: _____

Infancy:

Was the child vaccinated? ☐ Yes ☐ No

Immunization history (any complications or reactions): _____

_____

Was there any prolonged use of medicines or an inhaler? ☐ Yes ☐ No

If yes, which? _____

Did the infant suffer any traumas such as serious falls or car accidents? ☐ Yes ☐ No

Has the infant been under regular Chiropractic care? ☐ Yes ☐ No Doctor: _____

Name of Pediatrician: _____

Date of last visit: _____ Reason: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.)
Was this the case with your child? ☐ Yes ☐ No Explain:
_____

Feeding History:

Breast fed: ☐ Yes ☐ No How long: _____

Formula fed: ☐ Yes ☐ No How long: _____ Type: _____

Introduced to solids at: _____ months Cow's milk at _____ months

Food/juice allergies or intolerances: ☐ Yes ☐ No List: _____

Does your child have any feeding difficulties? _____

Does your child have any persistent or intermittent skin rashes? _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At was age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

Childhood Years:

Did the child have any childhood illnesses? ☐ Yes ☐ No Explain: _____

☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Rubella ☐ Rubeola ☐ Whooping Cough ☐ Other

Does the child play youth sports? ☐ Yes ☐ No Which sport(s)? _____

Has the child had any surgeries? ☐ Yes ☐ No Explain: _____

Has the child fallen from a height over 3 ft.? ☐ Yes ☐ No Explain: _____

Has there been any prolonged use of medications? ☐ Yes ☐ No Explain: _____

Has the child suffered any emotional traumas? ☐ Yes ☐ No Explain: _____

Has your child ever been involved in a car accident? ☐ Yes ☐ No Explain: _____

Has your child ever been seen on an emergency basis? ☐ Yes ☐ No

Explain: _____

Other traumas not described above? ☐ Yes ☐ No Explain: _____

Prior surgery: ☐ Yes ☐ No Explain: _____

Menarche: ☐ Yes ☐ No Age and any complaints: _____

Number of doses of antibiotics your child has taken:

During the past six months: _____ Total during his/her lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past six months: _____ Total during his/her lifetime: _____

Please list: _____

Please give us any other health information you may feel would be helpful: _____
_____
_____
_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to examine and provide chiropractic care for my child. I hereby authorize this clinic and its Doctor(s) to administer care as they so seem necessary to my son/daughter/ward (upon approval of parent or guardian). I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Parent's signature: _____ Date: _____