

Child's Name: \_\_\_\_\_ Name the child prefers to be called: \_\_\_\_\_

Name of Mom, Dad, or guardian: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Family E-mail: \_\_\_\_\_

Best place to reach you:  Home  Cell  Work: ( ) \_\_\_\_\_ ext: \_\_\_\_\_

Children's Siblings and ages (if applicable): \_\_\_\_\_

Who is your child's primary care doctor? \_\_\_\_\_  
(Please list the name of your child's doctor and the facility)

May we contact him or her about your care? Y N Were you referred by him or her? Y or N

**Insurance Information**

Are your child's symptoms related to an accident? Y N  Automobile  Work  Other Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current Complaints**

Major complaints and symptoms: 1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_

How do you believe the child's problem or pain began? \_\_\_\_\_

**Has your child seen any provider for this condition?**

**What did they do, and did it help?**

1. \_\_\_\_\_

\_\_\_\_\_ Y N

2. \_\_\_\_\_

\_\_\_\_\_ Y N

**On a Scale of 0—10, I rate my discomfort as follows:**

(zero being no pain, 10 being the worst pain I have ever felt)

Neck-Shoulder-Arm Pain



Mid Back Pain



Low Back- Leg Pain



**Vitamins and Supplements**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

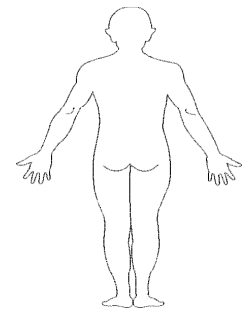
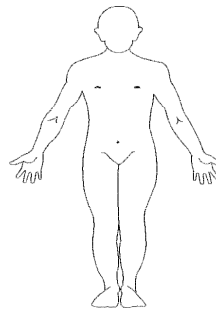
\_\_\_\_\_  
\_\_\_\_\_

**Medications (please write additional on separate sheet of paper)**

\_\_\_\_\_  
\_\_\_\_\_

**SHOW AREA(S) OF PAIN OR SYMPTOMS**

Mark the areas on this body where your child feels pain or symptoms.



**TRAUMA (if answer is yes– please list the approximate age of occurrence)**

Has your child had any recent falls or injuries? N Y: \_\_\_\_\_

Has your child ever fallen downstairs or fallen from any height? N Y: \_\_\_\_\_

Has your child ever been in a motor vehicle collision? N Y: \_\_\_\_\_

Has your child ever had a bone fracture or joint dislocation? N Y: \_\_\_\_\_

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades, or similar? N Y: \_\_\_\_\_

Has your child had any other trauma or injuries? N Y: \_\_\_\_\_

**NUTRITION (if answer is yes– please describe)**

Do you have any concerns about your child’s diet? N Y: \_\_\_\_\_

Does your child take vitamin supplements? N Y (see front section of listed supplements)

Does your child eliminate stools each day? N Y if no, how often? \_\_\_\_\_

How many glasses of water does your child drink each day? \_\_\_\_\_

How many cans of soda does your child drink each day? \_\_\_\_\_ Or, per week? \_\_\_\_\_

How much cow’s milk does your child drink each day? \_\_\_\_\_

Does your child eat fruits and vegetables? N Y \_\_\_\_\_

**GROWTH and HEALTH HISTORY (if the answer is yes, please describe briefly)**

Was your child born premature? N Y If yes, at what month / week was your child born? \_\_\_\_\_

Does your child ever complain of neck or back pain? N Y: \_\_\_\_\_

Does your child ever complain of pain in his/her arms or legs? N Y: \_\_\_\_\_

Does your child ever complain of headaches? N Y: \_\_\_\_\_

Does your child have a problem with bedwetting ( if potty-trained)? N Y: \_\_\_\_\_

Does your child have excessive belching or passing gas? N Y: \_\_\_\_\_

Does your child have any known food allergies? N Y (See the front box listed Allergies)

Does your child have frequent or occasional skin rashes? N Y: \_\_\_\_\_

Has your child ever had an upper respiratory infection? N Y If yes, at what age(s): \_\_\_\_\_

Has your child had asthma? N Y If yes, what age was it diagnosed? \_\_\_\_\_

Does your child have frequent earaches? N Y If yes, when did they start? \_\_\_\_\_

Has your child had any other significant illnesses? N Y: Chickenpox Strep Throat RSV bronchitis pneumonia

Has your child taken antibiotics? N Y If yes, how many treatments? \_\_\_\_\_

Is your child presently on any medications? N Y (See front box of listed medications)

Has your child been recently vaccinated? N Y Has your child been following the vaccination schedule? N Y

Has your child previously had chiropractic care? N Y If yes, date of last treatment? \_\_\_\_\_

Do you have any other concerns about your child’s health? \_\_\_\_\_