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| **Child Health History** |

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| **Personal Information** |  |  |
| Name | | Today’s Date |
| Street Address | | Date of Birth |
| City | State | Zip | | Gender |
| Email | | Phone |
| Parent/Guardian Name: | | Height: Weight: |
| Who is your child’s primary care provider? | | |
| How did you hear about Mindset Chiropractic? | | |

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| **Current Health Concern** |
| What is your main reason for seeking care at Mindset Chiropractic? |
| When did this condition begin? Was there an accident or injury involved? |
| Has your child had any past treatment for this condition? Y N  If yes please explain: |
| What makes the problem worse?  What makes the problem better? |
| Please list any drugs, supplements, or herbs that your child is taking: |
| What are you seeking from chiropractic care? Resolve current condition Overall wellness Both |
| Has your child seen a chiropractor? Y N If yes, what is their name? |

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| **Prenatal History** |
| Were there any complications during pregnancy? Y N  If yes, please explain: |
| Please list any medication(s) used during pregnancy:  Cigarettes or alcohol during pregnancy? Y N  Was mother ill during pregnancy? Y N  Any ultrasounds? Y N  Did mom exercise? Y N |
| Please explain any notable concerns or remarks about your child's conception or pregnancy: |

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| **Birth History** |
| Child’s birth was: Vaginal Planned cesarean Emergency cesarean  Child’s birth was at: Hospital Birth Center Home |
| Doctor/OB/Midwife name(s):  How many weeks was your child born? |
| Please check any complications or interventions:  Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps |
| Child’s birth weight: lbs oz Child’s birth height: in |

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| **Childhood Growth & Development** |
| Is/was your child breastfed? Y N If yes, for how long? Any difficulties?  Was formula ever used? Y N If yes, at what age? What Brand? |
| Does your child suffer from constipation, colic or infantile reflux? Y N  If yes, please explain: |
| At what age did the child:  Respond to sound: Follow an object: Hold head up: Vocalize: Teeth:  Sit alone: Crawl: Walk: Begin cows milk: Begin solid foods: |
| Please list any food allergies or intolerances, including date of onset:  How would you describe your child’s diet?  Mostly whole, organic foods Average diet Many processed foods |
| Please describe any surgeries or hospitalizations for your child including year: |
| Have you chosen to vaccinate your child? Y N  If yes, have you chosen a selective or delayed schedule? Y N  Please explain any reactions to the vaccines if applicable: |
| Does your child have difficulty sleeping? Y N  If yes, please describe: |
| Does your child have any behavioral or social difficulties? Y N  If yes, please explain: |

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| **Child Goals: please describe the top 3 goals for your child** |
| 1. |
| 2. |
| 3. |