Child Health History

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?	

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?

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:

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

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:

Child Goals: please describe the top 3 goals for your child

1.
2.
3.