Child Health History

Personal Information

Name
Gender ◯ M ◯ F

Parent/Guardian Name(s)

Street Address
City

State

Zip

Phone

Email

Birthdate

Age

Height ft. in.

Weight lbs.

Who is your child's primary care provider?

How did you hear about Lake Life Chiropractic?

Present Complaint

What is your main reason for seeking care at Lake Life Chiropractic?

When did this condition begin?

Was there an accident or injury involved?

Has your child had any past treatment for this condition? ◯ Yes ◯ No
If yes, please explain:

What makes the problem better?
What makes the problem worse?

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 ever seen a chiropractor? ◯ Yes ◯ No If yes, what is their name?

Prenatal History

Were there any complications during pregnancy? ◯ Yes ◯ No
If yes, please explain:

Please list any medication(s) used during pregnancy:

Cigarettes or alcohol during pregnancy? ◯ Yes ◯ No If yes, please explain:
Was mother ill during pregnancy? ◯ Yes ◯ No If yes, please explain:
Any ultrasounds? ◯ Yes ◯ No If yes, please explain:
Did mother exercise? ◯ Yes ◯ No If yes, please explain:

Please explain any notable concerns or remarks about your child's conception or pregnancy:

Birth History

Child's birth was: ◯ vaginal delivery ◯ planned cesarean birth ◯ emergency cesarean birth
Child's birth was at: ◯ home ◯ birth center ◯ hospital

Doctor/Obstetrician/Midwife Name(s):
At 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? ◯ Yes ◯ No If yes, how long? Any difficulty breastfeeding?
Was formula ever used? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child suffer from constipation, colic, infantile reflux? ◯ Yes ◯ No
If yes, please explain:

At what age did the child:
respond to sound follow an object hold their head up vocalize teeth
sit alone crawl walk begin cow's milk begin solid foods

Please list any food allergies or intolerances, including the 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 the year.

Have you chosen to vaccinate your child? ◯ Yes ◯ No
If yes, have you chosen a selective or delayed schedule? ◯ Yes ◯ No, on schedule
Please explain any reactions to the vaccines, if applicable.

Does your child have difficulty sleeping? ◯ Yes ◯ No
If yes, please describe:

Does your child have any behavioral or social difficulties? ◯ Yes ◯ No
If yes, please describe:

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

1.

2.

3.

Name_____ **Date**_____