

# PRE-SCHOOL CHILD HISTORY

## 3 years to 5 years

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Sex: M F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

How did you hear about our office or website? (Please list where you've seen/heard about our office or what web search you used.) \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Yes No

Does your child complain of discomfort? If yes, when did this occur? \_\_\_\_\_

Was onset: Sudden  or Gradual  Is problem: Constant  or Intermittent

Yes No

Has your child ever had this problem before? \_\_\_\_\_

Yes No

Has your child previously been treated for this problem? By whom? \_\_\_\_\_

Yes No

Has your child previously had chiropractic care? Previous chiropractor? \_\_\_\_\_

### NUTRITION

Yes No

Do you have any concerns about your child's diet? \_\_\_\_\_

Yes No

Does your child have any food allergies? \_\_\_\_\_

Yes No

Does your child have any persistent or intermittently occurring skin rashes? \_\_\_\_\_

Yes No

Does your child take vitamin supplements? \_\_\_\_\_

Yes No

Does your child eliminate stools each day? \_\_\_\_\_

For how many months was your child breast-fed? \_\_\_\_\_

What does your child usually eat for breakfast? \_\_\_\_\_

What does your child usually eat for lunch? \_\_\_\_\_

What does your child usually eat for dinner? \_\_\_\_\_

What does your child usually eat for snacks? \_\_\_\_\_

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

What is your child's favorite food? \_\_\_\_\_

What type of fast foods does your child like to eat? \_\_\_\_\_

**TRAUMA**

Yes No

Has your child had any recent falls or trauma? Describe the trauma and the date it occurred:

\_\_\_\_\_

Yes No

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

Yes No

Has your child ever fallen down stairs or fallen from a significant height? \_\_\_\_\_

Yes No

Has your child ever been in a motor vehicle collision or near-miss? \_\_\_\_\_

Yes No

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

Yes No

Has your child has any other trauma or injuries? \_\_\_\_\_

Yes No

Does your child ever bang his/her head repeatedly against a wall, bed or other object? \_\_\_\_\_

**HEALTH HISTORY**

Yes No

Has your child had asthma? \_\_\_\_\_

Yes No

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

Yes No

Does your child ever complain of pains in the arms or legs? \_\_\_\_\_

Yes No

Does your child ever complain of headaches? \_\_\_\_\_

Yes No

Is your child allergic to anything? \_\_\_\_\_

Yes No

Are there any smokers in the child's home? \_\_\_\_\_

Yes No

Has your child had any earaches? At what age did the first earache occur? \_\_\_\_\_

How frequently does your child have earaches? \_\_\_\_\_

Yes No

Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? \_\_\_\_\_

Yes No

Has your child had any other illnesses? Pleas list each illness and its approximate date: \_\_\_\_\_

\_\_\_\_\_

Yes No

Is your child presently receiving any medications? \_\_\_\_\_

Please list any surgeries your child has had: \_\_\_\_\_

Yes No

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