

SCHOOL-AGE CHILD HISTORY

6 Years and Older

Today's Date _____

Name _____ Sex: M F Date of Birth _____ Age _____

Reason for Today's visit _____

When did this problem first occur? _____

Have you ever had this problem before? Yes No _____

Have you previously been treated for this problem? Yes No Doctor's name _____

Have you previously been to a chiropractor? Yes No When? _____

ABOUT YOUR HEALTH:

In the past year, have you had any of the following:

Back or neck pain? Yes No _____

Pains in the legs or arms? Yes No _____

Headaches? Yes No _____

Asthma? Yes No _____

Earaches? Yes No _____

Allergies? Yes No _____

Falls from a bicycle, skateboard, scooter, rollerblades or similar? Yes No _____

Do you ever have a problem with bedwetting? Yes No _____

Have you ever been in a motor vehicle accident? Yes No _____

Have you ever had any broken bones? Yes No _____

Have you ever had any surgeries? Yes No _____

Are you presently taking any medications? Yes No _____

Do you have any other health problems? Yes No _____

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ABOUT YOUR LIFESTYLE:

What grade are you in at school? _____

How do you carry your school books? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET:

What do you usually eat for breakfast? _____

What do you usually eat for lunch? _____

What do you usually eat for dinner? _____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or colas do you drink each day? _____

How often do you eat fast food items? _____