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? _____

_____