

**SCHOOL AGE HISTORY**  
**3 years AND OLDER**

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

Child's Name \_\_\_\_\_ Sex M F    DOB \_\_\_\_\_ Age \_\_\_\_\_

Mother & Father's Name \_\_\_\_\_ Child's SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ email \_\_\_\_\_

How were you referred to the office? \_\_\_\_\_

Would you like to receive our free monthly health newsletter?     Yes         No         Already Receive

Reason for Today's Visit \_\_\_\_\_

Please give as much detail as you feel necessary to help the doctor understand your answers to the following questions.

Yes    No

Does your child complain of pain or discomfort?    If yes, when did this occur? \_\_\_\_\_  
Was onset    Sudden     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?    Pediatrician's name? \_\_\_\_\_

Yes    No

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

**Health History**

Yes    No

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

Yes    No

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

Yes    No

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

Yes    No

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

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 child's first earache occur \_\_\_\_\_?

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

In which ear do your child's earaches usually occur?    Right  Left  Both

Yes    No

Is your child taking any prescribed medication? \_\_\_\_\_

How many times has your child used antibiotics in the past 6 months? \_\_\_\_\_ Lifetime \_\_\_\_\_

Please list any other illness, which have been a concern for your child  
\_\_\_\_\_

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

Yes    No

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

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**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, roller blades 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 had any other trauma injuries? \_\_\_\_\_

Yes No

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

**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 are your child's 5 favorite foods? \_\_\_\_\_

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

Is there anything else you think we should know? \_\_\_\_\_

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_