# 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 Northern Peak Chiropractic?

## Present Complaint

What is your main reason for seeking care at Northern Peak 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**_____

Northern Peak Chiropractic
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