CHIROPRACTIC PRE-SCHOOL CHILD HISTORY
(3 to 5 years of age)

Date: ___/___/_____
Name of child: _____ Sex: M F Birthday: ___/___/____ Age: ___

The reason for today's visit: _____ T

**Yes No**

☐ ☐ **Does your child complain of pain or discomfort? _____**
**If yes, when did this pain occur? _____**
**Was the onset sudden or gradual? _____**
**Is the problem constant for intermittent? _____**
**Has your child ever had this problem before? _____**
**Has your child previously been treated for this problem? _____ By whom? _____**

**TRAUMA**

☐ ☐ **Has your child had any recent falls or trauma? _____**
☐ ☐ **Has your child ever fallen downstairs or fallen from any height? _____**
☐ ☐ **Has your child ever been in a motor vehicle collision? _____**
☐ ☐ **Has your child ever had a bone fracture for joint dislocation? _____**
☐ ☐ **Has your child had any other trauma or injuries? _____**
☐ ☐ **Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____**

**NUTRITION**

☐ ☐ **Do you have any concerns about your child's diet? _____**
☐ ☐ **Does your child take vitamin supplements? _____**
☐ ☐ **Does your child eliminate stool's each day? _____**
☐ ☐ **How much water does your child drink each day? _____**
☐ ☐ **How much soda pop does your child drink each day? _____**
☐ ☐ **How much cow's milk does your child drink each day? _____**

**GROWTH – DEVOLPMENT – HEALTH HISTORY**

☐ ☐ **Does your child have any digestive disturbances? _____**
☐ ☐ **Does your child have any food allergies? _____**
☐ ☐ **Does your child have any persistent or intermittent skin rashes? _____**
☐ ☐ **Is your child receiving any vitamin supplements? _____**
☐ ☐ **Has your child had any upper respiratory infections? _____**
☐ ☐ **Has your child had asthma? _____**
☐ ☐ **Does your child ever complain of back or neck pain? _____**
☐ ☐ **Does your child ever complained of pains in the arms or legs? _____**
☐ ☐ **Does your child ever complain of headaches? _____**
☐ ☐ **Has your child had any earaches? _____**
☐ ☐ **How frequently does your child have earaches? _____**
☐ ☐ **Do the earaches tend to occur in the same ear? _____**
☐ ☐ **Has your child had any other illnesses? _____**
☐ ☐ **Is your child presently receiving any medications? _____**
☐ ☐ **Has your child been recently vaccinated? _____**
☐ ☐ **Has your child previously had chiropractic care? _____**
☐ ☐ **Do you have any other concerns about your child's health? _____**

**Please list any surgeries your child has had: _____**

_____ _____
**Parent/Guardian's Signature** **Relationship to Child**