CHIROPRACTIC SCHOOL-AGE CHILD HISTORY
(6 years of age and older)

Date: ___/___/_____
Name of child: ______________________________ Sex: M F Birthday: ___/___/____ Age: ___
The reason for today's visit: ____
And when did this problem first occur? ____

Yes No

☐ ☐ **Have you ever had this problem before?** ______________________
☐ ☐ **Have you ever been treated for this problem before?** ______________________
☐ ☐ **Have you ever been to a chiropractor?** ______________________

ABOUT YOUR HEALTH

In the past year have you had any of the following?

☐ ☐ **Back or neck pain?** ______________________
☐ ☐ **Pain in the arms or legs?** ______________________
☐ ☐ **Headaches?** ______________________
☐ ☐ **Asthma?** ______________________
☐ ☐ **Allergies?** ______________________
☐ ☐ **Earaches?** ______________________
☐ ☐ **Falls from a bicycle, skateboard, skater, rollerblades or similar?** ______________
☐ ☐ **Do you ever have a problem with bed wetting?** ______________________
☐ ☐ **Have you ever been a car accident?** ______________________
☐ ☐ **Have you ever had any broken bones?** ______________________
☐ ☐ **Have you ever had any surgeries?** ______________________
☐ ☐ **Are you presently taking any medications?** ______________________

NUTRITION

☐ ☐ **Do you have any concerns about your diet?** ______________________
☐ ☐ **Do you take vitamin supplements?** ______________________
☐ ☐ **Do you have a bowel movement each day?** ______________________
☐ ☐ **How much water do you drink each day?** ______________________
☐ ☐ **How much soda pop do you drink each day?** ______________________
☐ ☐ **How much cow's milk to you drink each day?** ______________________

ABOUT YOUR LIFESTYLE

☐ ☐ **What grade are you in at school?** ______________________
☐ ☐ **How do you carry your schoolbooks?** ______________________
☐ ☐ **How heavy is your school book bag?** ______________
☐ ☐ **What sports to you play?** ______________________
☐ ☐ **What hobbies to 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 of 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?** ______________________
☐ ☐ **Have you previously had chiropractic care?** ______________________
☐ ☐ **Do you have any other concerns about your health?** ______________________

Please list any surgeries you have had: ______________________________

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