



Integrated Health Solutions

Child Health History

(Ages 2-12)

Name: _____ DOB: _____ Date: _____

Parent(s)/Guardian(s) Name(s): _____ Enrolled in Medicare? Yes No

Chief Complaint: _____

How and when did it start? _____

What makes it better? _____ What makes it worse? _____

Has your child been treated for this condition before? Yes No If yes, by whom? _____

Is your child currently under a healthcare provider's care for any other problems? Yes No

Previous Chiropractic Care: Last visit? Reason? Duration of care? _____

Current Medications/Antibiotics/Supplements: _____

Past Medications/Antibiotics: _____

Hospital/ER Visits/Surgeries? _____

Other Injuries/Accidents: _____

Prenatal History

Complications During Pregnancy: (circle, if any)

Toxemia Diabetes Morning Sickness Heartburn Back Pain Headaches Other

Mother's Health/Nutrition: (circle one) Poor Good Excellent

Stress During Pregnancy: (rate 1-10) _____ Falls/Injuries/Accidents During Pregnancy: _____

Family History of: (circle, if any) Diabetes Heart/Cardio Problems Other _____

Complications During Delivery: (circle)

None C-Section Vacuum/Forceps Induced Epidural Fetal Distress Meconium Oxygen ICU

Birth Injuries: (list) _____

Rate the Following:

	Poor		Average		Exceptional
General Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall Diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise Routine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What **Physical Stresses** has your child experienced (Sports Injuries, Poor Posture, etc.)? _____

Emotional Stresses (Fear, Family, Temper, etc.)? _____

Chemical Stresses (Second Hand Smoke, Sugar, etc.)? _____

Vaccines: (circle)

Reactions, if any: (fever, fussy, etc.)

Y N Partial Complete

Slight Mild Severe

Describe reactions: _____

Check any of the following that your child has suffered from:

- Allergies
- Asthma
- Attention/Hyperactivity
- Bedwetting
- Digestive Difficulties
- Ear Infections
- Foot/Hip/Leg Problems
- Head Banging or Headaches
- Heart Conditions
- Seizures
- Sleep Problems
- Spitting Up/Vomiting
- Vision Problems

Patient Name: _____ Signature: _____ Date: ___/___/___

Parent or Guardian: _____ Signature: _____ Date: ___/___/___