

PRE-SCHOOL CHILD HISTORY
3 years to 5 years

Today's Date _____

Child's Name _____ Sex: M F Date of Birth _____

Age _____

Reason for Today's Visit _____

Yes No

Does your child complain of pain or discomfort? If yes, when did this occur? _____

Was onset Sudden or 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? By whom? _____

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 _____

Yes No

How frequently does your child have earaches? _____

Yes No

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

Yes No

Is your child presently taking any prescribed medication? _____

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, rollerblades 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 or injuries? _____

Yes No

Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

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 is your child's favorite food? _____

What type of fast foods does your child like to eat? _____