



Child Health History Form

We are happy you have chosen to have your child's spine checked. Many types of stress (physical, mental, and chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions!

Child's Name _____ Date of Birth _____

Address _____ City/State _____ Zip _____

Home Phone _____ Parent's work phone _____

Mother's Name _____ Father's Name _____

Names and Ages of Siblings _____

Reason for consulting our office _____

Social Security # _____

Previous Chiropractic Care? Y/N If yes, with whom? _____

How Long was care received? _____ Last Check-up _____

Insured's SS# _____ Place of Work _____ Date of Birth _____

Circle Appropriately

Birth Place: Home/Birth Center/Hospital

Type: Vaginal/C-section

Procedures: Forceps/Vacuum Extraction

Was delivery long? Y/N Was delivery difficult? Y/N Labor Induced? Y/N

Epidural? Y/N Pain Medication? Y/N

Was baby breech/in utero-constraint? Y/N

Was baby breast fed? Y/N Duration _____

Which sports does/did your child participate in:

None/Soccer/Football/Gymnastics/Cheerleading/Karate/Basketball/Dance

Other(s) _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc...) during the first year of life. Has this happened to your child? Y/N Comments _____

List any other falls or accidents _____

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

(Circle 'P' if in the distant past, circle 'R' if in the past 6 months)

P/R Ear Infections	P/R Scoliosis	P/R Seizures
P/R Chronic colds	P/R Asthma/Allergies	P/R Digestive Problems
P/R Headaches	P/R ADD/ADHD	P/R Recurring Fevers
P/R Growing/Back Pains	P/R Colic	P/R Bed Wetting
P/R Constipation	P/R Head Banging	P/R Other:_____

List date and year of any surgeries or hospitalizations _____

MEDICATION

How many rounds of antibiotics has your child taken in the last 6 months?_____ Lifetime_____

Present prescription drugs_____

Past prescription drugs_____

Over the counter drugs (past 6 months) _____

FINANCIAL INFORMATION

Person responsible for account: _____

Are you planning to use some type of insurance? Y/N

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize D.R.E.A.M. Wellness and whomever they may designate to administer care, as they deem necessary to my son/daughter.

My presence is / is not necessary for care to be rendered (circle one).

Signed:_____

Today's Date: _____