Jackson Chiropractic Clinic

PEDIATRIC HEALTH HISTORY
6-10 years old

Identification Information

Full Name _____ Nickname _____
Last First MI

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

Guardian(s) Name & Relationship _____

Address_____

City _____ State _____ Zip Code _____

Phone Number _____ ☐ Home ☐ Cell ☐ Work

Insurance Information

Insurance Company _____ ☐ I do not have insurance.

Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Child History

Reason for today's visit: _____

How did this begin? _____ When did it start? _____

Was the onset: ☐ Sudden ☐ Gradual Is the problem: ☐ Constant ☐ Intermittent

Have you had this before? ☐ Yes ☐ No _____

Have you been treated for this problem? ☐ Yes ☐ No By whom? _____

Do you have any: ☐ Back pain ☐ Neck pain ☐ Arm pain ☐ Leg Pain ☐ Headaches

Any recent falls or trauma? ☐ Yes ☐ No _____

Have you fallen down stairs or from a significant height? ☐ Yes ☐ No _____

Have you been in a motor vehicle collision or near-miss? ☐ Yes ☐ No _____

Please list any injuries, surgeries, or hospitalizations: _____

_____

LIFESTYLE

What grade are you in at school? _____ How do you carry your school books? _____

What sports/hobbies do you have? _____

How much "screen time" do you have? _____ hours How much do you sleep at night? _____ hours

HEALTH HISTORY

Do you have frequent upper respiratory infections? ☐ Yes ☐ No If yes, how often? _____

Do you have a history of ear infections? ☐ Yes ☐ No

If **yes**: At what age(s)? _____ Which ear? ☐ Right ☐ Left ☐ Both

What was the treatment? _____

Do you have any persistent or intermittently occurring skin rashes? ☐ Yes ☐ No _____

Do you wear glasses or contact lenses? ☐ Yes ☐ No Do you ever have blurred vision? ☐ Yes ☐ No

Do you have trouble reading the board in class? ☐ Yes ☐ No

What do you usually eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Do you eliminate stools every day? ☐ Yes ☐ No

Allergies (medication or environmental): _____

Please list all medications (prescription and non-prescription) and all nutritional/herbal supplements you are taking, plus the dosage and frequency:

_____

_____

Have you been to a chiropractor before? ☐ Yes ☐ No

Guardian Signature _____ Date _____