

## GENERAL HEALTH HISTORY

Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

**Past Present**

- Headaches
- Ear Infections
- Colic
- Allergies / Asthma
- Medication Side Effects
- Recurring Fevers
- Digestive problems
- Bed Wetting
- Chronic Colds/Sinus
- Other \_\_\_\_\_

**Past Present**

- Vision Problems
- Sleeping Problems
- Growing Pains
- Dental Problems
- Temper Tantrums
- ADHD
- Seizures
- Scoliosis
- Ever Needed Stitches

1. List any medications being taken: \_\_\_\_\_
2. Number of courses of Antibiotics child has taken in the last 6 mo. \_\_\_\_\_ Total during lifetime \_\_\_\_\_
3. Name of Pediatrician and Other Doctors: \_\_\_\_\_
4. Date of Last Visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_
5. Name of Obstetrician/Midwife: \_\_\_\_\_
6. Location of Birth:  Hospital  Birthing Center  Home
7. Complications During Pregnancy:  No  Yes Explain: \_\_\_\_\_
8. Ultrasounds During Pregnancy:  No  Yes How Many: \_\_\_\_\_
9. Medication During Pregnancy / Delivery  No  Yes List: \_\_\_\_\_
10. Cigarette / Alcohol Use during Pregnancy:  No  Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

12. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_
13. List any past falls bumps bruises: \_\_\_\_\_ Was any care received? \_\_\_\_\_
14. List any past sport, recreational, or home injuries: \_\_\_\_\_
15. Please describe any past conditions and treatment received: \_\_\_\_\_  
\_\_\_\_\_
16. Please list any past hospitalizations and surgeries: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY

- Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Is there any other family history you want us to know? \_\_\_\_\_