Child History Form

Date ______________

Child's Name ____

Address ____

City ____ Zip Code ___________________________

Name(s) of Parent(s) or Guardian(s) ____

Phone number prefer to be reached at ____

Email: ____

DOB __________________ Child's Height _________ Child's Weight _____________

Pediatrician's Name _____________________________________ Date of last visit w/ Pediatrician __________

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature ____

Witness _______________________________ Who may we thank for referring you? _______________________

Have you seen a Chiropractor before? _____________

What are your chief concerns, if any, with your child's health? _________________________________

What is your main reason for contacting us? ____

List any other care your child has undergone with regards to this complaint including medication

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Date of onset _______________________

Initiating Factors ____

Aggravating Factors ____

Relieving Factors ____

How does the problem affect your child's body function & daily activities? ___________________________

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