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 _____

How frequently does your child have earaches? _____

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 occuring 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? _____