Braile Chiropractic

Child Health History Form

To be filled out by parent or guardian. Please print clearly and fill in completely.

Print Child's Name _____ **Date of Birth** _____

Street Address _____ **Apt.#**_____

City _____ **State** _____**Zip**_____ **Phone** _____

Please Check ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑

Health History:

Give reason for seeking chiropractic care:_____

_____

Describe any other health problems: _____

_____

Is the child under the care of any other doctor? Yes❑ No❑ If Yes, explain conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates:_____

List any past accidents & dates:_____

List any x-rays the child had in the past 2 years: _____

Chiropractic History:

Has child ever been to a Chiropractor before? Yes❑ No❑ If yes, Doctor's Name_____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays_____ How long was child under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who?_____

Rate Your Child's Overall Health

At Braile Chiropractic we are dedicated toward achieving the goal of total lasting health for each of our practice members. To better help achieve this; we need to understand how you view your child's overall health. Based on a scale of 10% to 100%, please **circle** what you feel is your child's current level of health and wellness.

10%-------- 20% --------30%-------- 40% --------50%-------- 60% --------70%-------- 80% --------90% ------- 100%

Additional Health History Information

Please describe any other health history information you feel would assist us in the care of your child?

_____

_____

I authorize examination and care for the minor listed above as I am this child's parent or legal guardian.

Print Parent's Name:_____

Parent's Signature: _____ **Date:** _____

Please continue on the second page of this form

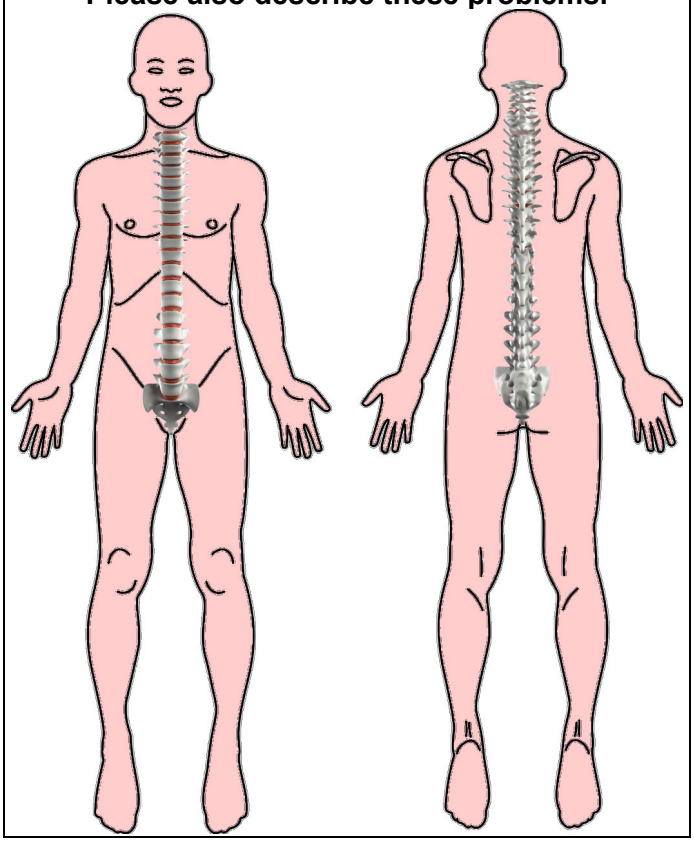
Please Fill in Below

Has you child currently or recently suffered from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headaches	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Muscle pain	❑	❑
Growing pains	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Ear infections	❑	❑
Earaches	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Frequent colds	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Asthma	❑	❑
Allergies	❑	❑
ADHD	❑	❑
Hyperactivity	❑	❑
Hypoglycemia	❑	❑
Diabetes	❑	❑
Eating Disorders	❑	❑
Digestive problem	❑	❑
Skin conditions	❑	❑
Learning Disabilities	❑	❑

Please make sure you have signed and dated side one of this form.

Circle the areas where your child has any pain or health problems.
Please also describe these problems.



Please use the space below to fill in any additional health information you feel we may need for your child's care.

_____

_____

_____

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