



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 health problems, including how long you've had them: _____

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 you've had in the past 2 years: _____

Chiropractic History:

Have you 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 were you under care? _____

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

Rate Your Child's Overall Health

At Braille Chiropractic we are dedicated toward achieving your goal of total lasting health for each of our practice members. To better help you 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 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 your child currently or recently suffered from the following, Please Check ✓

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

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.

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