

HEALTH 4 LIFE
MINOR HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____

Name of Parents / Guardians: _____

Purpose For Contacting Us? _____

Other Doctors Seen for this Condition: _____ N _____ Y, Doctors' Names and Prior Treatments: _____

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma / Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing / Back Pains
Colic	Bed Wetting	Skin Problems	Temper Tantrums	
Other _____				

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are you Satisfied with the Care Your Child has Received There? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____, Total During His / Her Lifetime: _____

Vaccination History: _____

Prenatal History:

(Please fill out to the best of your ability)

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____ N _____ Y, List: _____

Ultrasounds During Pregnancy ? _____ N _____ Y, Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y, List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Caesarian Section, Emergency or Planned?

Complications During Delivery ? _____ N _____ Y, List: _____
Genetic Disorders or Disabilities: _____ N _____ Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interference). At what age was your child able to:

_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ N _____ Y, List: _____

Has Your Child Ever Been Involved in a Car Accident ? _____ N _____ Y, List: _____

Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y, List: _____

Other Traumas Not Described Above? _____ N _____ Y, List: _____

Prior Surgery: _____ N _____ Y, List: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other _____	N / Y, Age _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILDS RESULTS.
AUTHORIZATION FOR CARE OF MINOR**

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____ Date: _____ / _____ / _____
