Child History Form

Princeton Chiropractic Wellness Center

Welcome to the Princeton Chiropractic Wellness Center. Please fill in the following completely and clearly. **Date:** _____

CONTACT INFORMATION (please print clearly):

Child's Name: _____ Parent's Name: _____
Address: _____ Phone (Home): _____
City: _____ State: _____ Zip code: _____ (Work): _____
Date of Birth: _____ Age: _____ (Cell): _____
How did you find out about our office? _____
E-mail address: _____ May we send you our office newsletter? ☐ Yes ☐ No

Health Profile

1. Has your child benefitted from chiropractic care? __Yes __No When was his/her last visit? _____

2. **Circle Appropriately**
   Birth Place: Home / Hospital / Birth Center
   Type: Vaginal / C-Section
   Procedures: Forceps / Vacuum Extraction

3. **Circle Appropriately**
   Which contact sports does your child participate in?
   Soccer / Football / Gymnastics / Karate / Hockey
   Basketball / Dance / Other _____

3. According to the National Safety Council, approximately 50% of infants fall head first from a high place bed, changing table, etc.) during their first year of life. Has this happened to your child? __ Yes __No

4. 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 or Back Pains
   ☐ Colic ☐ Bed Wetting ☐ Car Accident ☐ Temper Tantrums ☐ Other _____

5. How many prescriptions of antibiotics has your child taken:
   During the past 6 months ____, Total during His/Her Lifetime ____

6. How many other prescription medications has your child taken:
   During the past 6 months ____, Total during His/Her Lifetime ____

7. What is your purpose in having your child checked in our office? _____
   _____

Medication Usage

1. When your child exhibits symptoms do you bring him/her right to the doctor? __Yes __No
   If no, how long do you typically wait? _____

2. When your child exhibits symptoms do you medicate him/her immediately or do you wait? If you wait, for how long? _____

3. Is your child currently on any medications? __Yes __No If yes, please list _____
   _____

4. Do you give your child any nutritional supplements? Please list _____
   _____

Which best describes your reason for consulting our office?

☐ I have a specific concern and require help only with this concern.
☐ I want to ensure that my child's health concerns do not become an ongoing problem that will impact his/her future health.
☐ I want my child to be healthier in five years than he/she is today.