Child Health Assessment

Child's Name: ______________________ Birthdate: ____/____/____ Age: ______

Address: ____
(street) (city) (state) (zip code)

Parent's / Guardian's names: ______________________

Home phone: ( ) ______________

Office phone: ( ) ______________

Cell phone: ( ) ______________

Email: ______________

What prompted you to bring your child in for care here **today**?

____

Have you seen other doctors for this concern? Y / N

If Yes, please list their name and what they did? ______________________

____

Does your child experience any health problems? Y / N

If Yes, please describe: ______________________

____

Has your child's spine ever been professionally evaluated? Y / N

By whom and when? ______________________

Since problems that chiropractors see can be related to many types of stressors, the following information is helpful for us:

Part I: Physical Stresses

Early Physical Stresses	YES	No	Comments:
Were there any complications during this child's pregnancy?	❑	❑	
Did you choose to have any ultrasounds performed during pregnancy?	❑	❑	
Did you have any falls or accidents while pregnant with this child?	❑	❑	
Were there any complications with this child's delivery?	❑	❑	
Was there any type of birth intervention used during delivery? (ie. Forceps, vacuum extraction, ceasarian section)	❑	❑	

Childhood Physical Stresses	YES	No	Comments:
Has your child ever had a fall from a high place? (ie. bed, stairs, etc.)	❑	❑	
Is or has your child been involved in any high impact sports? (ie. Soccer, football, gymnastics, martial arts, roller sports, etc.)	❑	❑	
Has your child ever been involved in a car accident?	❑	❑	
Has your child experienced any other traumas not described above?	❑	❑	
Has your child had any hospitalizations or surgeries?	❑	❑	

Childhood Diseases and/or Conditions:

❑chicken pox	❑chronic colds	❑digestive problems	❑temper tantrums
❑rubella / measles / mumps	❑ear infections	❑bed wetting	❑cystic fibrosis
❑whooping cough	❑colic	❑seizures	❑muscular dystrophy
❑rubeola	❑asthma / allergies	❑ADD / ADHD	❑other ______

Part II: Mental / Emotional Stresses

If your child is old enough, please allow them to help you fill out this section.

	MILD		MODERATE		EXTREME		NOT AT ALL	Comments:
	Past	Present	Past	Present	Past	Present		
School stress / pressure	❑	❑	❑	❑	❑	❑	❑	
Parents separated / divorced	❑	❑	❑	❑	❑	❑	❑	
Feel depressed / bored	❑	❑	❑	❑	❑	❑	❑	
Pressure to fit in with friends	❑	❑	❑	❑	❑	❑	❑	
Significant move	❑	❑	❑	❑	❑	❑	❑	
Family stress	❑	❑	❑	❑	❑	❑	❑	
Loss of loved one	❑	❑	❑	❑	❑	❑	❑	

Do sleeping patterns seem normal to you? (night terrors, difficulty sleeping/waking, etc.) ❑ Yes ❑ No

Explain: ______________________________

Do you notice a change in your child's behavior? ❑ Yes ❑ No

Explain: ______________________________

Part III: Chemical and Dietary Stress

These stresses are cumulative over the course of your child's life.

	DAILY		WEEKLY		MONTHLY		YEARLY		NOT AT ALL
	Past	Present	Past	Present	Past	Present	Past	Present	
alcohol (during pregnancy)	❑	❑	❑	❑	❑	❑	❑	❑	❑
tobacco use (during pregnancy)	❑	❑	❑	❑	❑	❑	❑	❑	❑
antibiotics and medicines	❑	❑	❑	❑	❑	❑	❑	❑	❑
childhood vaccinations	❑	❑	❑	❑	❑	❑	❑	❑	❑
sporadic eating	❑	❑	❑	❑	❑	❑	❑	❑	❑
diet food / artificial sweeteners	❑	❑	❑	❑	❑	❑	❑	❑	❑
meat products	❑	❑	❑	❑	❑	❑	❑	❑	❑
dairy products	❑	❑	❑	❑	❑	❑	❑	❑	❑
soda	❑	❑	❑	❑	❑	❑	❑	❑	❑
processed / fried foods	❑	❑	❑	❑	❑	❑	❑	❑	❑

Thank you for your trust and confidence.

Notes: ______________________________