McAuliffe Chiropractic Office

Pre-School Child History
3 Years to 5 Years

Patient's Name: _____ Parent's Name: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Sex: M F D.O.B. _____ Age: _____ SS#: _____

Reason for Today's visit? _____

When did this problem occur? _____

YES☐ NO☐ Does your child complain of pain or discomfort? _____

Was onset: Sudden ☐ or Gradual ☐ Is problem: Constant ☐ or Intermittent ☐

YES☐ NO☐ Has your child ever had this problem before? _____

YES☐ NO☐ Has your child previously been treated for this problem? By whom? _____

YES☐ NO☐ Has your child previously had chiropractic care? _____

Health History

YES☐ NO☐ Does your child ever complain of back or neck pain? _____

YES☐ NO☐ Does your child ever complain of pains in the arms or legs? _____

YES☐ NO☐ Does your child ever complain of headaches? _____

YES☐ NO☐ Had your child had asthma? _____

YES☐ NO☐ Is your child allergic to anything? _____

YES☐ NO☐ Are there any smokers in the child's home? _____

YES☐ NO☐ Has your child had any earaches? Is it right, left or both? _____

At what age did the child's first earache occur? _____

How frequently does your child have earaches? _____

YES☐ NO☐ Has your child had any other illnesses? If yes, what other illnesses? _____

Please list any surgeries your child has had: _____

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YES☐ NO☐ Is your child presently receiving and medications? Please list: _____

TRAUMA

YES☐ NO☐ Has your child had any recent falls or trauma? _____

YES☐ NO☐ Has your child ever fallen down stairs or fallen from any height? _____

YES☐ NO☐ Has your child ever been in a motor vehicle accident? _____

YES☐ NO☐ Has your child ever fallen from a bike, skateboard, scooter, rollerblades, etc?

YES☐ NO☐ Has your child ever had a bone fracture or dislocation? _____

YES☐ NO☐ Has your child had any other trauma or injuries? _____

YES☐ NO☐ Does your child ever bang their head repeatedly against a wall, bed, etc? _____

NUTRITION

YES☐ NO☐ Do you have any concerns about your child's diet? _____

YES☐ NO☐ Does your child take a multi-vitamin supplement? _____

YES☐ NO☐ Does your child have any food allergies? _____

YES☐ NO☐ Does your child have any persistent or intermittent skin rashes? _____

YES☐ NO☐ Does your child eliminate stool each day? _____

For how many months was your child breast fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

What type of fast foods does your child like to eat? _____

What is your child's favorite food? _____

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