

MCAULIFFE CHIROPRACTIC OFFICE

SCHOOL-AGED CHILD HISTORY

6 YEARS AND OLDER

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 Has this problem ever happened before? _____

YES NO Has this problem been previously treated? By whom? _____

YES NO Has the patient had previous chiropractic care? _____

HEALTH HISTORY

IN THE PAST YEAR, HAVE ANY OF THE FOLLOWING OCCURRED:

YES NO Back or neck pain? _____

YES NO Pains in the arms or legs? _____

YES NO Headaches? _____

YES NO Asthma? _____

YES NO Allergies? _____

YES NO Any problems with bedwetting? _____

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

YES NO Any earaches? At what age did the first earache occur? _____

How frequently are these earaches? _____ Is it right, left or both? _____

YES NO Any other illnesses? If yes, what other illnesses? _____

YES NO Presently receiving any medications? Please list: _____

MCAULIFFE CHIROPRACTIC OFFICE

YES NO Ever been to the emergency room or hospital for evaluation or treatment?

YES NO Please list any surgeries: _____

YES NO Any other concerns about your child's health? _____

TRAUMA

YES NO Any *recent* falls or trauma? _____

YES NO Ever fallen down stairs or fallen from any height? _____

YES NO Ever been in a motor vehicle accident? _____

YES NO Ever fallen from a bike, skateboard, scooter, rollerblades or similar? _____

YES NO Ever had a bone fracture or dislocation? _____

YES NO Any other trauma or injuries? _____

NUTRITION

YES NO Any concerns about the child's diet? _____

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

YES NO Does the child have any food allergies? _____

YES NO Does the child have any persistent or intermittent disturbances? _____

YES NO Does the child eliminate stool each day? _____

For how many months was the child breast fed? _____

What does the child usually eat for breakfast? _____

What does the child usually eat for lunch? _____

What does the child usually eat for dinner? _____

What does the child usually eat for snacks? _____

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

What is the child's favorite food? _____

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