SCHMITZ CHIROPRACTIC
Family Wellness Center

CHILDHOOD HEALTH HISTORY

Patient's Name:____

Has your child been to a Chiropractor before? YES NO

Purpose for contacting us?_______________________________________

Have you been to other health care providers? YES NO

Doctor's names and prior treatments:______________________________

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Does your child have any other health problems?______________________

____

Please circle any of the conditions your child has suffered from during the past six months:

Ear infections	Scoliosis	Seizures	Chronic colds	Headaches
Asthma/Allergies	Digestive problems	ADHD	Colic	Back Pain
Car Accident	Recurring Fevers	Bed Wetting	Temper Tantrum	Other

Family History of illness:____

____

Name of Pediatrician____

Phone:_____________________Date of last visit______________________

Reason for last visit____

Are you satisfied with the care you received there? YES NO

Antibiotics your child has taken: ___________________________________

During the past six months_______Total during his/her lifetime________

Other medications your child has taken (including non-prescription):

____

During the past six months_______Total during his/her lifetime________

Vaccination History:____

Has your child ever been involved in a car accident? YES NO

If yes, when?____

Has your child ever been seen on an emergency basis? YES NO

If yes, when and what for?_______________________________________

Other traumas not described above?________________________________
Any surgeries?____

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

Hold head up____________________ Sit up ______________________
Crawl ____________________ Stand alone______________________
Walk ____________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, down stairs, etc.). Was this the case with your child? YES NO

Is/has your child ever been involved in any high impact or contact sports? (Soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)
____
____

Childhood diseases:

Chicken Pox	Y/N, Age_______	Mumps	Y/N, Age_______
Rubella	Y/N, Age_______	Rubeola	Y/N, Age_______
Whooping cough	Y/N, Age_______	Other	Y/N, Age_______

Authorization to Treat a Minor

I hereby authorize treatment of my son/daughter as deemed necessary by Schmitz Chiropractic.

SIGNATURE:________________________________DATE:_____________