



# Hollis Family Chiropractic Center, PLLC

## Child Health History Form

4 Market Place, PO Box 1585, Hollis, NH 03049  
p: 603.465.2235 f: 603.465.2236

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: [ ] Male [ ] Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Reason for consulting our office: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

How did you hear about us?:

[ ] Yellow pages [ ] Lecture [ ] Drive by [ ] Coupon [ ] Website [ ] Other \_\_\_\_\_

[ ] Screening Where: \_\_\_\_\_ [ ] Mailing Which one: \_\_\_\_\_

### Health Profile

*Why is this form important? As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.*

#### Addressing the issues that brought you to the office:

If your child has no symptoms or complaints, and is here for **wellness services**, please check

Otherwise briefly describe the chief area of complaint, including the effect it has on the child:

\_\_\_\_\_

If he/she is experiencing pain, is it:  sharp  dull  comes & goes  travels  constant

Since the problem started, is it:  about the same  getting better  getting worse?

What makes it worse? \_\_\_\_\_

It interferes with:  school  sleep  walking  sitting  hobbies  other: \_\_\_\_\_

Other doctors seen for this problem:

Chiropractor: \_\_\_\_\_

Medical doctor: \_\_\_\_\_

Other: \_\_\_\_\_

List medications the child is taking or surgeries the child has had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Daily we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges that have influenced your child's health potential.*

**Pregnancy:**

Were there any complications to the pregnancy? \_\_\_\_\_

Was Mom on any medications, prescriptions or over-the-counter?  Yes  No

If yes, please explain: \_\_\_\_\_

Did Mom or Dad smoke during pregnancy?  Yes  No Who? \_\_\_\_\_

Was the baby ever in Breech position?  Yes  No

How many ultrasounds were performed? \_\_\_\_\_

Name of Midwife or Gynecologist: \_\_\_\_\_

**Birth and Delivery:**

Where was the baby born?  home  hospital  birthing center  other: \_\_\_\_\_

Was the delivery:  vaginal  c-section Were there any devices used?  forceps  vacuum

How long was the labor? \_\_\_\_\_ How long was the delivery? \_\_\_\_\_

Was oxytocin/pitocin used?  Yes  No Was an epidural administered?  Yes  No

Birth weight: \_\_\_\_\_ Current weight: \_\_\_\_\_

Additional comments: \_\_\_\_\_

**Infancy:**

Was the child vaccinated?  Yes  No

Immunization history (any complications or reactions): \_\_\_\_\_

Was there any prolonged use of medicines or an inhaler?  Yes  No If yes, which? \_\_\_\_\_

Did the infant suffer any traumas such as serious falls or car accidents?  Yes  No

Has the infant been under regular Chiropractic care?  Yes  No Doctor: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child?  
 Yes  No Explain: \_\_\_\_\_

**Feeding History:**

Breast fed:  Yes  No How long: \_\_\_\_\_

Formula fed:  Yes  No How long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to solids at: \_\_\_\_\_ months Cow's milk at \_\_\_\_\_ months

Food/juice allergies or intolerances:  Yes  No List: \_\_\_\_\_

**Developmental History:**

*During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).*

At what age was your child able to:

- |                                 |                   |
|---------------------------------|-------------------|
| _____ Respond to Sound          | _____ Cross Crawl |
| _____ Respond to Visual Stimuli | _____ Stand Alone |
| _____ Hold Head Up              | _____ Walk Alone  |
| _____ Sit up                    |                   |

**Childhood Years:**

Did the child have any childhood illnesses?  Yes  No Explain: \_\_\_\_\_

Chicken Pox  Mumps  Measles  Rubella  Rubeola  Whooping Cough  Other

Does the child play youth sports?  Yes  No Which sport(s)? \_\_\_\_\_

Has the child had any surgeries?  Yes  No Explain: \_\_\_\_\_

Has the child fallen from a height over 3 ft.?  Yes  No Explain: \_\_\_\_\_

Has there been any prolonged use of medications?  Yes  No Explain: \_\_\_\_\_

Has the child suffered any emotional traumas?  Yes  No Explain: \_\_\_\_\_

Has your child ever been involved in a car accident?  Yes  No Explain: \_\_\_\_\_

Has your child ever been seen on an emergency basis?  Yes  No Explain: \_\_\_\_\_

Other traumas not described above?  Yes  No Explain: \_\_\_\_\_

Prior surgery:  Yes  No Explain: \_\_\_\_\_

Menarche:  Yes  No Age and any complaints: \_\_\_\_\_

Number of doses of antibiotics your child has taken:

During the past six months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

Number of doses of other prescription medications your child has taken:

During the past six months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

Please list: \_\_\_\_\_

Please give us any other health information you may feel would be helpful: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to examine and provide chiropractic care for my child. I hereby authorize this clinic and its Doctor(s) to administer care as they so seem necessary to my son/daughter/ward (upon approval of parent or guardian). I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.*

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_