School-Age Child History

The following questions are designed to help the doctor provide the best possible spinal care for your child:

Reason for today's visit: ______________________________

	YES	NO	
Does your child complain of pain/discomfort?	☐	☐	If yes, when did it start? ____________
Was the onset: ☐ Sudden ☐ Gradual			Is the problem ☐ Constant ☐ Intermittent
Has your child had this issue before?	☐	☐	____________
Has your child been treated before for this issue?	☐	☐	____________ By whom? ____________
Has your child previously had chiropractic care?	☐	☐	____________ Previous chiropractor: ____________

HEALTH HISTORY

In the past year, have you had any of the following?

	YES	NO	
Neck/back pain?	☐	☐	____________
Headaches?	☐	☐	____________
Pain in arms and/or legs?	☐	☐	____________
Asthma?	☐	☐	____________
Allergies?	☐	☐	____________
Earaches/infections?	☐	☐	If yes, how often? ____________ At what age was the first earache? ____________
Do the earaches tend to occur in the same ear?	☐	☐	If yes, which side? ____________
Do you have a problem with bedwetting?	☐	☐	____________
Falls from a bike/scooter/rollerblades?	☐	☐	____________
Been in an auto accident or near miss?	☐	☐	____________
Have you ever had a fracture or dislocation?	☐	☐	____________
Have you had any other illnesses?	☐	☐	____________ ____________
Are you presently taking any medications?	☐	☐	____________
Have you been hospitalized?	☐	☐	____________
Have you had any surgeries?	☐	☐	____________
Do you have any other concerns you wish to address	☐	☐	

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School-Age Child History

LIFESTYLE

What grade are you in at school? ____

How do you carry your school bags? ____

How heavy is your book bag? ______________ How much time total do you carry your bag? ____________________

What sports do you play? ____

What hobbies do you have? ____

How many hours per day do you watch T.V? __________ Videogames? ______________ Ipad/Phone? ________________

On average how many hours per night do you sleep? _______________

Are there any smokers in your family? ____

Do you feel stressed out? ____

Do you have trouble reading the board in class? ____

Do you ever have blurred vision? _________________ Do you wear contacts/glasses? ____________________________

Do you get headaches when you read? _____________________ In school? ____________________________

DIET HISTORY

	YES	NO	
Do you have any concerns about your child's diet?	☐	☐	________________________
Does your child have any food allergies?	☐	☐	________________________
Does your child have any persistent skin rashes?	☐	☐	________________________
Is your child taking any nutritional supplements?	☐	☐	________________________
Does your child eliminate stools every day?	☐	☐	________________________

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 snacks does your child typically have? ____

How much dairy milk does your child drink each day? ________________________ Soda? __________________________

How much water does your child have each day? ____

Does your child eat fast food? ☐ ☐ If yes, how often? ______________________________

What is your child's favorite food? ____________________ Least favorite food? ______________________________