Preschool 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

Does your child complain about neck/back pain?	☐	☐	_____
Does your child ever complain about headaches?	☐	☐	_____
Does your child complain about arm/leg pain?	☐	☐	_____
Has your child had asthma?	☐	☐	_____
Does your child have any allergies?	☐	☐	_____
Has your child had any ear aches/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? _____
Has your child had any other illnesses?	☐	☐	_____ _____
Is your child presently taking any medications?	☐	☐	_____
Has your child been hospitalized?	☐	☐	_____
Has your child had any surgeries?	☐	☐	_____
Has your child been to the E.R for eval/treatment?	☐	☐	_____
Has your child recently been vaccinated?	☐	☐	_____
Which vaccines were recently administered?			_____
Do you have any other concerns you wish to address	☐	☐	

_____
_____
_____
_____

Preschool Child History

TRAUMA

Has your child had any recent falls/trauma? ☐ ☐ _____

Describe the trauma and the date it occurred: _____

Has your child fallen down stairs/from any height? ☐ ☐ _____

Has your child fallen from a bike/scooter/rollerblades? ☐ ☐ _____

Has child been in an auto accident or near miss? ☐ ☐ _____

Has your child ever had a fracture or dislocation? ☐ ☐ _____

Has your child banged their head repeatedly on a wall? ☐ ☐ _____

Has your child had any other trauma? ☐ ☐ _____

Has child ever had any negative reaction to a vaccine? ☐ ☐ _____

NUTRITION

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? ☐ ☐ _____

How many months was your child breast fed? _____ Formula fed? _____ Age of first solid: _____

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? _____

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? _____