AULT CHIROPRACTIC
HUDSON • BRIMFIELD

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# Children's Application for Care/Health History Form

**Name**______________________________**Age:**____________**Date:**____________

**Address:**________________________**City:**____________**State:**________**Zip:**________

**Mother's Name:**________________________**Father's Name:** ____________________

**Cell Phone:**____________ **Home Phone:**______________ **Work Phone:**__________

**SSN:**________________**Birth Date:**____________**Male:** □ **Female:** □

**Reason for consulting our office:**__________________________________________

**Who may we thank for you referring you?**____________________________________

## Health Profile

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

**If he/she is experiencing any pain, is it**: □ sharp □ dull □ comes and 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:__________________________________________

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**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 to your child's health potential.

## Pregnancy:

**Were there any complications to the pregnancy**? Explain:____________________________________

______________________________________________________________________________________

**Was Mom on any medications, prescriptions or over the counter medicines**? □ Yes □ No If Yes, please explain:______________________________________________________________

**Did Mom or Dad smoke during pregnancy**? □ Yes □ No Who?______________________________

**Was the baby ever in breach position?** □ Yes □ No

**How many ultrasounds were performed**?___________________________________________________

## Birth and Delivery:

**Where was the baby born**: □ Home □ Hospital □ Birthing Center □ Other ___________________

**Was the delivery**: □ Vaginal □ C-section **Were 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

## Infancy:

**Was the infant vaccinated**? □ Yes □ No

**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

## Childhood years:

**Did the child have any childhood illnesses**? □ Yes □ No Explain: ___________________________

**Does the child play any sports**? □ Yes □ No Which sport? ___________________________________

**Has child had any surgery**? □ Yes □ No Explain:_____________________________________________

**Has the child fallen from a height over 3 ft**? □ Yes □ No Explain: ___________________________

**Was the child involved in any car accidents**? □ Yes □ No When? ____________________________

**Has there been any prolonged use of meds**? □ Yes □ No Explain:____________________________

**Has the child suffered emotional traumas**? □ Yes □ No Explain:____________________________

**Please give us any other health information you 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 chiropractically examine and care for my child.

**Parents signature**: _________________________________________________________ **Date**: ________________