PRE-SCHOOL CHILD HISTORY
3 years to 5 years

Date: ____________________________

Patient's Name: _________________________ Sex: M__ F__ Date of Birth______________ Age: _________

Reason for Today's Visit: ____

Yes No
☐ ☐ Does your child complain of pain or discomfort? _________Is yes, when did this occur? _____________

Was onset: Sudden ☐ or Gradual ☐ Is problem: Constant ☐ or Intermittent ☐

Yes No
☐ ☐ Has your child ever had this problem before? ____

Yes No
☐ ☐ Has your child previously been treated for this problem? _________By whom? _____________________

Yes No
☐ ☐ Has your child previously been under chiropractic care? _______Previous chiropractor _____________

HEALTH HISTORY

Yes No
☐ ☐ Does your child ever complain of back or neck pain? ____

Yes No
☐ ☐ Does your child ever complain of pains in the arms or legs? ___________________________________

Yes No
☐ ☐ Does your child ever complain of headaches? ____

Yes No
☐ ☐ Has your child had any earaches? _____ At what age did the first earache occur? __________________

How frequently does your child have earaches? ____

In which ear do your child's earaches usually occur? Right ☐ Left ☐ Both ☐

Yes No
☐ ☐ Has your child had asthma? ______

Yes No
☐ ☐ Is your child allergic to anything? ____

Yes No
☐ ☐ Is your child presently taking any medications? ____

Yes No
☐ ☐ Are there any smokers in the child's home? ____________

Please list any other illness which have been a concern for your child____________________________________

Please list any surgeries your child has had ____

Yes No
☐ ☐ Do you have any other concerns about your child's health? _____________________________________

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TRAUMA

Yes No
☐ ☐ Has your child had any recent falls or trauma? ______________
Describe the trauma and the date it occurred ____

Yes No
☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? ________________

Yes No
☐ ☐ Has your child ever fallen down stairs or fallen from a significant height? ___________________________

Yes No
☐ ☐ Has your child ever been in a motor vehicle collision or near-miss? _______________________________

Yes No
☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____________________________________

Yes No
☐ ☐ Has your child had any other trauma or injuries? ____

Yes No
☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object? _______________

NUTRITION

Yes No
☐ ☐ Do you have any concerns about your child's diet? ____

Yes No
☐ ☐ Does your child have any food allergies? ____

Yes No
☐ ☐ Does your child have any persistent or intermittently occurring skin rashes? _______________________

Yes No
☐ ☐ Does your child take vitamin supplements? ____

Yes No
☐ ☐ Does your child eliminate stools each day? ____

For how many months was your child breast-fed? ____

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 does your child usually eat for Snacks? ____

How much cow's milk does your child drink each day? ____

What is your child's favorite food? ____

What type of fast foods does your child like to eat? ____

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