

## KIDS Health Check-up Form

(Please fill out this form thoroughly to determine if any health problems your child may be experiencing could be improved through Chiropractic.)

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Previous Chiropractic Care Y/ N \_\_\_\_\_

Please select any of the applicable reasons for your pursuing chiropractic care for your child:

\_\_\_ He/she is continuing care from another chiropractor.

\_\_\_ I recently had my spine checked and see the value in a family subluxation check-up.

\_\_\_ I'm concerned about his/her health and am looking for answers.

\_\_\_ He/she has a specific condition that concerns me.

If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

Do you have family members with similar health concerns? \_\_\_\_\_ If so, who? \_\_\_\_\_

Has he/she ever been diagnosed with cancer? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

Surgeries your child has had: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Number of doses of Antibiotics your child has taken:

During the past 6 months: \_\_\_\_\_ Total during Lifetime: \_\_\_\_\_

Number of doses of other prescription medications taken:

During the past 6 months: \_\_\_\_\_ Total during Lifetime: \_\_\_\_\_

List any current medications: \_\_\_\_\_

List any past medications: \_\_\_\_\_

In order to better understand your child's current level of health, please check any of the following body signals that your child has had or has previously had:

\_\_\_ Headaches \_\_\_ Postural Imbalances \_\_\_ Growing Pains \_\_\_ Scoliosis \_\_\_ Frequent Colds

\_\_\_ Asthma \_\_\_ Allergies \_\_\_ Ear Infections \_\_\_ Seizures \_\_\_ Stomach/Digestive trouble

\_\_\_ Digestive Problems \_\_\_ Bedwetting \_\_\_ PDD/Autism \_\_\_ ADD/ADHD \_\_\_ Colic

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

### Prenatal History:

Adopted? Y / N

Complications during pregnancy? \_\_\_\_\_. If so, please explain:

\_\_\_\_\_

Medications/drugs/caffeine during pregnancy? \_\_\_\_\_. If so, please list type and amount:

\_\_\_\_\_

Cigarette/Alcohol use during pregnancy? \_\_\_\_\_. If so, please list type and amount: \_\_\_\_\_

Location of birth: \_\_\_ Hospital \_\_\_ Birthing Center \_\_\_ Home  
Birth Intervention: \_\_\_ Mother Induced \_\_\_ Mother Medicated (Pitocin, etc.) \_\_\_ Forceps  
\_\_\_ Vacuum Extracted

Delivery Process: \_\_\_ Vaginal \_\_\_ C-Section

Baby given Medication after delivery: Y / N List: \_\_\_\_\_

Complications during delivery? \_\_\_\_\_. If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Genetic Disorders/Disabilities? \_\_\_\_\_. If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Breast Fed? \_\_\_ How long? \_\_\_\_\_ Formula Fed? \_\_\_ How long? \_\_\_\_\_

**According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.).**


Was this the case with your child? \_\_\_\_\_. Please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? \_\_\_\_\_. If so, please list:  
\_\_\_\_\_  
\_\_\_\_\_

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

X- hypertonic musculature; P-pain; T-tenderness	Doctor Screening Form
	Prone leg length equality: Y / N Short on - Left / Right Medial arch equality: Y / N Collapsed on -Left / Right Achilles bowing present: Y / N Left / Right Gluteal line: Midline / Left / Right Other: