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Child / Adolescent / Teenager - HISTORY FORM (6 years old and UP)

Child's Name: _____ Male Female Today's Date: _____

Age: _____ Birthdate: _____

Parent's Name: _____ Date: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Parent's Social Security#: _____ Driver's Lic# _____

Occupation/Employer's Name and address _____

Single _____ Married _____ Divorced _____ Widowed _____

Spouse's Name _____

Spouse's Occupation/Employer: _____

No. of children: _____

Reason for Consulting our Office? _____

Who may we Thank for referring you to our office? _____

YOUR CHILD'S HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on you and your child's ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses your child has faced in during his/her lifetime, allowing us to better assess the challenges to your child's health potential.

THE REASON FOR YOUR VISIT IS: (PLEASE CHECK ALL THAT APPLY)

- Wellness – I just want my child to have a spinal checkup.
- Pain / Symptom – Please use the space below to tell us more:
 - ❖ When did it start? _____
 - ❖ How long has it been going on? _____
 - ❖ Is it a Pain or other symptom? How would you describe it? _____
 - _____
 - ❖ What have you tried to this point to help? _____
 - ❖ Have you taken your child to the pediatrician for this issue? ___Y ___N
If yes, who is your child's pediatrician? _____
What kind of care / treatment was recommended? _____
 - ❖ Is there any other information we should regarding this issue? _____
 - _____
 - _____

GROWTH AND DEVELOPMENT:

- * Do sleeping patterns seem to be normal? YES NO, explain? _____
- * Do eating patterns seem to be normal? YES NO, explain? _____
- * Any health problems on the mother's side of the family? NO YES, explain? _____
- * On father's side of the family? NO YES, explain? _____
- * Any health problems with brothers or sisters? NO YES, explain? _____
- _____
- * Any allergies? If so, list them here: _____

SINCE MANY PROBLEMS CAN BE RELATED TO MANY TYPES OF STRESSORS, THE FOLLOWING INFORMATION IS VERY IMPORTANT....

PHYSICAL/TRAUMATIC STRESSORS:

- * Any falls from couches, beds, or other? NO YES, explain? _____
- _____
- * Any surgeries? NO YES, explain? _____
- * Play sports at ANY TIME IN PAST? NO YES, which ones and when? _____
- _____

CHEMICAL STRESSORS:

- * Any pets at home? NO YES, what kind and how many? _____
- * Any smokers that live in the home? NO YES, explain? _____
- * Any Vaccinations? NO Yes – ALL to Date Yes - Some, List _____
- * Any antibiotics use NO YES, when was first course of antibiotics given? _____
- TOTAL number of courses of antibiotics give to date? _____
- * CURRENT MEDICATIONS: _____

EMOTIONAL/PSYCHOSOCIAL STRESSORS:

Average number of hours of television / video games per week? _____

Does your child seem normal for his/her age? YES NO, explain? _____

Other Emotional Stressors we should know about? _____

Please list any additional information you would like us to know about your child:

Parent/Guardian (PRINT NAME)

Parent/Guardian (SIGNATURE)

DATE