Child's Health History Form
Healing Hands Chiropractic
1019 N Highland Ave, Murfreesboro, TN 37130 Phone: 615-203-3505

Name: _____ Age: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Father's Name: _____

Phone #: _____ SSN: _____ Birth date: _____ □ Male □ Female

Parent's Email: _____

Whom may we thank for referring you? _____

Health Profile

Reason(s) for consulting our office: _____

_____

_____

If your child has no symptoms or complaints, and is here for wellness services, please check: ☐

If he/she is experiencing 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? _____

What have you tried to fix it? _____

It interferes with: ☐ School ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Other: _____

Other doctors seen for this problem:

Pediatrician: _____ Ph # _____

Medical Group:_____ Ph # _____

Chiropractor: _____ Ph # _____

Other: _____ Ph # _____

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 you child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? ☐ Yes ☐ No
If yes, explain: _____

Did Mom or Dad smoke during pregnancy? ☐ Yes ☐ No Who? _____

Was the baby ever in the Breech position? ☐ Yes ☐ No
How many ultrasounds were preformed? _____

Birth & 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 as 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 youth sports? ☐ Yes ☐ No Which sport(s)? _____

Has the 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 Explain: _____

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.

Parent's Signature: _____ Date: _____