PRE-SCHOOL CHILD HISTORY

(3 to 5 years of age)

Date: ___________ Name of Mother: __________________ Name of Father: __________________

Name of child: ____________________________ Sex: M F Date of Birth: ___/___/____ Age: ____

The reason for today's visit: ____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur? ________________

Was the onset sudden or gradual? ____

Is the problem constant or intermittent? ____

☐ ☐ Has your child ever had this problem before? ___________________________________

☐ ☐ Has your child previously been treated for this problem? By whom? _______________________

☐ ☐ Has your child previously had chiropractic care?

If yes, where? ________________________ If yes, by whom? _____________________

NUTRITION:

☐ ☐ Do you have any concerns about your child's diet? __________________________________

☐ ☐ Does your child have any food allergies? _______________________________________

☐ ☐ Does your child have any persistent or intermittent occurring skin rashes? __________________

☐ ☐ Does your child take vitamin supplements? _____________________________________

☐ ☐ Does your child eliminate stools each day? _____________________________________

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

What does your child usually eat for Breakfast? ____

Lunch? ____________________________________ Dinner? ________________________________

Snacks? ___________________________________ Favorite Food? ___________________________

How much does your child drink each day of: Water _______________ Cow's Milk___________________

Soda/Pop __________________________ Juice/Sports Drinks ____________________________

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

TRAUMA:

☐ ☐ Has your child had any recent falls or trauma? ____

Describe the trauma and the date it occurred ____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?

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☐ ☐ Has your child ever fallen downstairs or from a significant height? ________________________

☐ ☐ Has your child ever been in a motor vehicle collision or a near miss? _______________________

☐ ☐ Has your child ever had a bone fracture or joint dislocation? ___________________________

☐ ☐ Has your child had any other trauma or injuries? ______________________________________

☐ ☐ Does your child bang his/her head repeatedly against a wall, bed or other object? ____________

☐ ☐ Does your child enjoy participating in any organized sports? ____________________________

HEALTH HISTORY:

☐ ☐ Does your child ever complain of back or neck pain? ___________________________________

☐ ☐ Does your child ever complain of pains in the legs or arms? ____________________________

☐ ☐ Does your child ever complain of headaches? ____

☐ ☐ Has your child had asthma? ____

☐ ☐ Is your child allergic to anything? ____

☐ ☐ Are there any smokers in the child's home? ____________________________________

☐ ☐ Has your child had any earaches?

At what age did the child's first earache occur? ______________________________

How frequently does your child have earaches? _____________________________

Do the earaches tend to occur in the same ear? Right ☐ Left ☐ Both ☐

☐ ☐ Is your child presently taking any prescribed medication? _______________________________

Please list any other illnesses that have been a concern for your child ______________________________

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Please list any surgeries your child has had ____

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Do you have any other concerns about your child's health? ___________________________________