SCHOOL-AGE CHILD HISTORY

(6 years of age and older)

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? _____

ABOUT YOUR HEALTH:

In the past year have you had any of the following?

☐ ☐ Back or neck pain? _____

☐ ☐ Pains in the arms or legs? _____

☐ ☐ Headaches? _____

☐ ☐ Asthma? _____

☐ ☐ Allergies? _____

☐ ☐ Earaches? _____

☐ ☐ Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____

☐ ☐ Do you ever have a problem with bedwetting? _____

☐ ☐ Have you ever been in a motor vehicle accident? _____

☐ ☐ Have you ever had any broken bones? _____

☐ ☐ Have you ever had any surgeries? _____

☐ ☐ Are you presently taking any medications? _____

☐ ☐ Do you have any other health problems? _____

ABOUT YOUR LIFESTYLE:

What grade are you in at school? _____

How do you carry your schoolbooks? _____

How heavy is your school bookbag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours of sleep do you get each night? _____

☐ ☐ Are there any smokers in your family? _____

☐ ☐ Do you feel stressed out? _____

☐ ☐ Do you have trouble reading the board in class? _____

☐ ☐ Do you ever have blurred vision? _____

☐ ☐ Do you wear glasses or contact lenses? _____

☐ ☐ Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET:

☐ ☐ Do you take vitamin supplements? _____

☐ ☐ Do you have a bowel movement each day? _____

☐ ☐ Do you have any persistent or intermittent occurring skin rashes? _____

☐ ☐ Do you have any food allergies? _____

What do you usually eat for Breakfast? _____

Lunch? _____ Dinner? _____

Snacks? _____ Favorite Food? _____

How much do you drink each day of: Water _____ Cow's Milk _____

Soda/Pop _____ Juice/Sports Drinks _____

What type of fast foods do you like to eat? _____