Weum Chiropractic
Children's Health History

Name ______________________________ Date ______________________

Parents/Guardians ______________________________ Social Security # ______________

Address ______________________ City/State ______________ Zip __________

Home Phone ______________________ Parent Work/Cell ______________________

Date of Birth ________________ Referred By ______________________________

Past Chiropractic Care? Yes/No Dr.'s Name/Location __________________ Last Visit _______

Current Medical Care? Yes/No Why? ____

Current Medications ____

Reason For Consulting This Office ____

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1. **How often do you experience your symptoms?**

   - ☐ Constantly (76-100% of the time)
   - ☐ Occasionally (26-50% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Intermittently (1-25% of the time)

2. **How would you describe the type of pain?**

   - ☐ Sharp
   - ☐ Burning
   - ☐ Tingly
   - ☐ Electric like w/motion
   - ☐ Dull
   - ☐ Shooting
   - ☐ Sharp w/ motion
   - ☐ Other:____________
   - ☐ Diffuse
   - ☐ Stiff
   - ☐ Shooting w/ motion
   - ☐ Achy
   - ☐ Numb
   - ☐ Stabbing w/ motion

3. **How are your symptoms changing with time?**

   - ☐ Getting worse
   - ☐ Staying the same
   - ☐ Getting better

4. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

   0 1 2 3 4 5 6 7 8 9 10

5. **Who else have you seen for this problem?** ________________________________

6. **How long have you had this problem?** _______yrs _______mnths _______wks _______days

7. **How do you think this problem began?**________________________________

8. **What makes the problem worse?** ________________________________

9. **What makes the problem better?** ________________________________

10. **What concerns you the most about this problem; What does it prevent you from doing?** ______________

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11. **What sports/activities do you do?** ____

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12. **Anything else pertinent to your visit today?** ______________________________________

13. **Check any of the following conditions your child has suffered from in the present/past:**

☐ Ear Infections	☐ Scoliosis	☐ ADHD	☐ Seizures
☐ Sleeping Problems	☐ Headaches	☐ Colic	☐ Recurring Fevers
☐ Car Accident	☐ Bed Wetting	☐ Chronic Constipation	☐ Spitting Up
☐ Temper Tantrums	☐ Asthma/Allergies	☐ Digestive Problems	☐ Chronic Colds

☐ Other: ____

14. **Has there been significant past trauma?** ☐No ☐ Yes, ______________________________

15. **Were there any complications during pregnancy?** ☐No ☐Yes, ________________________

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16. **Were there any complications during delivery?** ☐No ☐ Yes, __________________________

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The doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease. *Thomas A. Edison*

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I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature ____ Date ____________________