Ht:	All:
Wt:	BP:
For office use only	

Skadsem Weum Chiropractic
Children's Health History
(Children 5 & under)

Name ______________________________ Date ____________________

Parents/Guardians ______________________________ Parent SS # ____________________

Address ______________________________City/State ____________________Zip __________

Home Phone ____________________ Parent Cell ____________________ ___Mom ___Dad

Call or Text Reminder __________Date of Birth __________ Referred By ____________________

Past Chiropractic Care? Yes/No Dr.'s Name/Location ____________________ Last Visit __________

Current Medical Care? Yes/No Why? ______________________________

Current Medications/Vitamins______________________________

Reason for consulting this office ______________________________

____

1. **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

2. **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)

3. **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

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

   - Getting worse
   - Staying the same
   - Getting better

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?** ________
____

11. **What daily activities do you do?** ____
____

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, ____
____

16. **Were there any complications during delivery?** ·No · Yes, ____
____

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

We Accept Payment By Cash, Check And Credit Card

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.

Parent Signature:____ Date:_____________________