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

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

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:_____