Child's Name ________________________________ Age _________________________ Date _____________________
Address ____
City ____ State __________________ Zip ___________________________
Date of Birth ________________________________ Gender ____
Parent's Name ________________________________ Phone # Home/Cell ___________________________ _________
Parent's E-mail ____
Parent's Status (Circle One) Married Single Divorced Separated Widowed
Child's Recreation Activities____
School _________________________________ Grade ____
Sibling's Names, Ages, and Health Status ____
____
Has your child been checked by a chiropractor? **Yes** / **No** Chiropractor's Name _________________________________
Date of Last Visit: _______________________________

Health History Information

What is your main concern? ______________________
____
____

What are your expectations?______________________
____
____

List Medications: ______________________________
____
____

Surgeries / Procedures and Dates:_________________
____

What do you do to keep yourself healthy? ___________
____

Family Health History: ___________________________
____

Smoking History? **Yes** / **No** _______________________

Rate Your Stress

(Circle a number to rate each. 0 = none, 10 = maximum)

Physical Stress (i.e. heavy lifting, excessive sitting, play…)
0 1 2 3 4 5 6 7 8 9 10

Chemical Stress (i.e. toxin exposure, medications, nutrition)
0 1 2 3 4 5 6 7 8 9 10

Emotional Stress (i.e. friends, family, school, financial)
0 1 2 3 4 5 6 7 8 9 10

List Any Other Major Stresses: ____________________
____

List Major Traumas or Accidents & Dates:_____________
____

Diagnostic Imaging:____________________________
Sleep Habits: _________________________________
Age That You Learned To Walk: ___________________
Bedwetting? **Yes / No** ___________________________

Female Information

Are you taking any form of birth control? **Yes / No** ________
Menstruation? **Yes / No** Age:_______________________
Are you pregnant? **Yes / No** Due Date: _________________

Office Use: ____
____
____

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

Legal Guardian Name____ Date_____________________________

Relationship to Minor _____________________________ Witness Signature (Office Staff) ______________________

Legal Guardian Signature____

principle, PLE Chiropractic, colorado springs, co