Life is Good Chiropractic
HC1, Box 10, Brodheadsville, PA 18322

**CHILDREN'S HEALTH HISTORY** **Dr Initials BG / JK**

CHILD'S NAME: ______________________ PM#________ AGE: _______ DATE: ______________
PARENTS/GUARDIANS ______________________________________________
ADDRESS ______________________________________________
CITY ______________________ STATE ______________ ZIP ______________
HOME PHONE ______________________ WORK PHONE ______________________
BIRTHDATE ______________ MALE _____ FEMALE _____ SS# ______________
OTHER CHILDREN'S NAMES & AGES ______________________________________________
______________________________________________

CHIROPRACTIC HISTORY:

HAS THE CHILD HAD PAST CHIROPRACTIC CARE BEFORE? YES _____ NO ______
CHIROPRACTOR'S NAME & LOCATION: ______________________________________________
WHEN WAS THE LAST VISIT ?______________________________________________

CURRENT MEDICAL CARE? WHY? ______________________________________________
______________________________________________

CURRENT DRUGS/MEDICATION? ______________________________________________
______________________________________________

REASON FOR CONSULTING THIS OFFICE? ______________________________________________
______________________________________________

WHO SHOULD WE THANK FOR TELLING YOU ABOUT US? ______________________________
______________________________________________

PLEASE CHECK THE CHOICE THAT MOST CLOSELY
DESCRIBES CURRENT
GOALS FOR YOUR CHILD'S HEALTH/WELL-BEING

◊ I want optimum health and well-being on every level for my child.
◊ I am concerned about relief of a particular symptom.
◊ I am concerned about relief of a particular symptom and preventing its return.

**Children should have their spines checked on a regular basis for subluxations.**
**It is vital for their life and health to have an optimal functioning nerve system.**

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Child's Name: ______________________________ PM # ____________

**PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH BIRTH**

(Please check any that apply)

**During Pregnancy** Explain: ______________________________
- ◊ Drugs/medicine
- ◊ Tobacco/alcohol
- ◊ Illnesses

**During Labor and Delivery** Explain: ______________________________
- ◊ Labor chemically incuded
- ◊ Labor doctor assisted
- ◊ C-section delivery
- ◊ Forceps/vacuum extraction
- ◊ Doctor pull or twist baby
- ◊ Premature delivery

**Since Birth** Explain: ______________________________
- ◊ Nursed how long ________
- ◊ Baby jaundiced
- ◊ Feeding problems
- ◊ Sleeping problems
- ◊ Colic

**Vaccinations**
- ◊ None
- ◊ Only selected vaccines ______________________________
- ◊ Delayed schedule ______________________________
- ◊ Regular schedule
- ◊ Any vaccine reactions ______________________________

**PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD**

(Please mark any that apply)

Explain: ______________________________
- ◊ Any falls or injuries
- ◊ Respiratory problems
- ◊ Ear infections
- ◊ Allergy/Asthma
- ◊ Bedwetting
- ◊ Digestive problems
- ◊ Hyperactivity
- ◊ Hospitalized
- ◊ Other health problems
- ◊ Sports (min. past 5 yrs): Type: ______________________________Hours per week ________
  - ◊ Recreational ◊ Competitive
- ◊ Hours of video games, computer time, TV watching per day: ____________
- ◊ Other hobbies/activities: ______________________________
- ◊ General mood/emotional state: ______________________________
- ◊ Significant behavior traits: ______________________________

ANY OTHER PAST OR CURRENT HEALTH COMPLAINTS? ______________________________

______________________________

I hereby authorize Life Is Good Chiropractic, LLC to provide chiropractic care as may be deemed necessary to my child/ward. I am aware that my insurance will be billed for the performed services.

Parent/Guardian Signature: ______________________________ Date: ______________