

THE CONNECT CHIROPRACTIC

1210 6th St. Ste. #103

Nevada, Iowa 50201

GENERAL HEALTH HISTORY

Patient Name _____

Mark the conditions that apply to you.

Past Present

- Headaches
- Ear Infections
- Colic
- Allergies / Asthma
- Medication Side Effects
- Recurring Fevers
- Digestive problems
- Bed Wetting
- Chronic Colds/Sinus

Past Present

- Vision Problems
- Sleeping Problems
- Growing Pains
- Dental Problems
- Temper Tantrums
- ADHD
- Seizures
- Scoliosis
- Ever Needed Stitches

Other

1. List any medications being taken: _____

2. Number of courses of Antibiotics child has taken in the last 6 mo ___ Total during lifetime___

3. Name of Pediatrician and Other Doctors:

4. Date of Last Visit ____/____/____

Reason: _____

5. Name of Obstetrician/Midwife: _____

6. Location of Birth: Hospital Birthing Center Home

7. Complications During Pregnancy: No Yes
Explain: _____

8. Ultrasounds During Pregnancy: No Yes How Many: _____

9. Medication During Pregnancy / Delivery No Yes
List: _____

10. Cigarette

/ Alcohol Use during Pregnancy: No Yes

11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":
No Yes Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____

13. List any past falls bumps bruises: _____
Was any care received? _____

14. List any past sport, recreational, or home injuries: _____

15. Please describe any past conditions and treatment received:

16. Please list any past hospitalizations and surgeries:

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis
Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis
Other _____

Is there any other family history you want us to know?
