Children's Health History

NAME:_______________________________________DATE:______________

PARENTS/GUARDIAN:____

ADDRESS:____

CITY/STATE:________________________________ZIP CODE:___________

HOME PHONE:_____________________WORK PHONE:_________________

BIRTHDATE:______________OTHER CHILDREN-NAMES/AGES___________

____

WHO REFERED YOU TO THIS OFFICE?:______________________________

PAST CHIROPRACTIC CARE? YES/NO, DR.'S NAMES/LOCATION:__________

____LAST VISIT:_____________

CURRENT MEDICAL CARE? YES/NO WHY?:___________________________

CURRENT DRUGS/MEDICATION:_____________________________________

REASON FOR CONSULTING THIS OFFICE:____________________________

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PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR CHILD'S HEALTH/WELLBEING.

- ▫ I am only concerned about relief of a particular symptom.
- ▫ I am only concerned about relief of a particular symptom, and preventing its return.
- ▫ I want optimum health and wellbeing on every level for my child.

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 writing.

Signature:_________________________________ ____________Date:________________

Alive & Well Chiropractic, Dr. Anne Marie Marcellino, 2 Linden Street, Suite 101, Reading, MA 01867, Phone: (781-942-7121)

PERSONAL HISTORY

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of vertebral subluxations.

Stress that may be physical, chemical or emotional may cause these subluxations.

The practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation.

PLESE TELL US ABOUT ANY STRESS ASSOCIATED WITH BIRTH:

(Please circle any that apply)

During Pregnancy:

1) Drugs/medicine Yes / No
2) Tobacco/alcohol Yes / No
3) Illness during Yes / No

Explain:_____________________________________
____
____

During Labor & Delivery:

1) Labor chemically induced? Yes / No
2) Labor doctor assisted? Yes / No
3) C-section delivery? Yes / No
4) Forceps/vacuum extraction? Yes / No
5) Doctor pull or twist baby? Yes / No
6) Premature delivery? Yes / No

Explain:_____________________________________
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Since Birth:

1) Nursed how long? _____________
2) Baby Jaundiced? Yes / No
3) Feeding Problems? Yes / No
4) Sleeping Problems? Yes / No
5) Colic? Yes / No
6) Vaccinations? Yes / No

Explain:_____________________________________
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PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

1) Any falls or injuries? Yes / No
2) Respiratory problems? Yes / No
3) Ear infections? Yes / No
4) Allergy/Asthma? Yes / No
5) Bedwetting? Yes / No
6) Digestive problems? Yes / No
7) Hyperactivity? Yes / No
8) Other health problems? Yes / No
9) Hospitalized? Yes / No

Explain:_____________________________________
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Anything else:____
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I hereby authorize the above named doctor(s) and whoever may be designated as assistants; to provide chiropractic care as may be deemed necessary to my child/ward.

Signature:_________________________________ _____________Date:_________________

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