

Houk Chiropractic Clinics Child Health History Form

3809 N. Monroe
Spokane, WA 99205

9720 N. Nevada
Spokane, WA 99218

Child's Name: _____ Age: _____ Sex: M / F DOB: _____

Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Mother's Work Phone: _____ Mother's Cell Phone: _____

Father's Work Phone: _____ Father's Cell Phone: _____

Names and Ages of Siblings: _____

Reason for Today's office Visit: _____

Previous Chiropractic Care: Y / N If yes, With Whom? _____ Date of Last Visit: _____

How long was care received? _____ For what condition? _____

Please Circle Appropriately:

Birth Place: Home / Birth Center / Hospital / Other _____

Type of Birth: Vaginal / Planned C-Section / Emergency C-Section Premature / Full-Term

Delivered by: Midwife / Obstetrician Procedures: Forceps / Vacuum Extraction / Other _____

Was Delivery Long: Y / N, Time: _____ Was Delivery Difficult: Y / N Labor Induced: Y / N Epidural: Y / N

Pain Medication: Y / N Was Baby Breech: Y / N Was Baby Brest Fed: Y / N For How long? _____

Did any of the following happen to the mother during the pregnancy (please circle all that apply):

Allergies Depression Mostly Happy Medications Recreational Drugs

Premature Labor Physical Injury Mental Trauma Tobacco Use Alcohol Use

Caffeine Hospitalization Weight Loss Bleeding Immunizations

Back Pain Complications Gestational Diabetes New Illness Diagnosed: _____

Toxic Exposures Chiropractic Care Prenatal Care Prenatal Classes

Vitamins / Supplements Preclampsia / High Blood Pressure

Which Sports does / did your child participate in? _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc...) durring the first year of life. Has this happened to your child? Y / N

List any falls / accidents: _____

For Children under the age of 2, Have they received any of the following:

Breast Milk Cow's Milk Soy Milk Goat's Milk Other Milk: _____

Sweets Vitamins Medication Fruits and / or Juice Veggies and / or Juice

Solid Foods Organic Foods Formula / Soy based Other _____

Were any of the following involved with this child's birth:

Medication Respirator Choking Crying Jaundiced
Pale in Color Sleeping Concerns Bottle Feeding Breast Feeding

Check any of the following conditions your child has suffered from:

(Circle "P" if in the distant past, circle "R" if in the past 6 months)

P / R Ear Infections P / R Headaches P / R Colic P / R Clumsy
P / R Ear Aches P / R Not Sleeping P / R Nose Bleeds P / R Walk "funny"
P / R Chronic Colds P / R Vomiting P / R Fainting P / R Fall Often
P / R Asthma P / R Allergies P / R Eczema / Skin Problems
P / R Scoliosis P / R Growing / Back Pain P / R Recurring Fevers: How Often? _____
P / R Bed Wetting P / R Constipation P / R Easily Fatigued
P / R Head Banging P / R Temper Tantrums P / R ADD / ADHD
P / R Seizures: Type _____ How Often _____
P / R Digestive Problems _____
P / R Other: _____

MEDICAL

Pediatrician's Name: _____ Date of Last Visit: _____

Any problems at that time? _____

List Date / Year of any surgeries or hospitalizations: _____

How many rounds of antibiotics has your child taken in the last 6 months: _____ Year: _____

Present prescription drugs: _____

Past prescription drugs: _____

Over the counter drugs (past 6 months) _____

Family Health History

Do any family members have any of the following:

Asthma Hypertension Liver Disease Kidney Disease Allergies Cancer
Diabetes Heart Disease Mental Illness Scoliosis Ulcers Eczema
Hypoglycemia Mental Retardation Other: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Houk Chiropractic Clinic and whomever they may designate to administer the care deemed necessary to my son / daughter

My presence **IS / IS NOT** necessary for care to be rendered (please circle one)

Signed: _____ Date: _____

Relationship to child: _____