



# VAN FAMILY CHIROPRACTIC

DR. ERIN VAN VELDUIZEN

## Child History Form

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Parent/Guardian Names \_\_\_\_\_

Address \_\_\_\_\_

Street or PO Box

City

State

Zip

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How many siblings? \_\_\_ Names & Ages of Siblings: \_\_\_\_\_

Referred to Dr. Erin by: \_\_\_\_\_

Purpose for Visit: \_\_\_\_\_ Have you seen any other Dr. for this? Y N

Describe Treatment given: \_\_\_\_\_

Check any conditions your child has suffered from:

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Ear Infections            | <input type="checkbox"/> Scoliosis               | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Chronic Colds             | <input type="checkbox"/> Digestive Problems      | <input type="checkbox"/> Colic        |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Allergies               | <input type="checkbox"/> ADD/ADHD     |
| <input type="checkbox"/> Recurring Fevers          | <input type="checkbox"/> Bed Wetting             | <input type="checkbox"/> Car Accident |
| <input type="checkbox"/> Sports Injury             | <input type="checkbox"/> Growing Pains           | <input type="checkbox"/> other Pain   |
| <input type="checkbox"/> Temper Tantrums           | <input type="checkbox"/> Difficulty Sleeping     | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Slow Physical Development | <input type="checkbox"/> Slow Mental Development | <input type="checkbox"/> Other _____  |

Please list any and all traumas or injuries child has experienced: \_\_\_\_\_

Has your child fell head first from a high place? \_\_\_\_\_

Please list & describe any surgeries your child has had: \_\_\_\_\_

Number of medications or Antibiotics child has taken in the past year: \_\_\_\_\_ Lifetime: \_\_\_\_\_

Please name any and all medications child is taking right now including OTC: \_\_\_\_\_

Please describe child's normal diet on a daily basis: \_\_\_\_\_

Does your child do any physical activity? Please describe what type & how often: \_\_\_\_\_

### Prenatal & Birth History:

Complications during pregnancy? Y N if yes, please describe: \_\_\_\_\_

Ultrasounds during pregnancy? Y N if yes, how many & during which month? \_\_\_\_\_

Any medications taken before or during delivery? \_\_\_\_\_

Alcohol/Cigarettes/Drugs during pregnancy? Y N Was your baby full-term? \_\_\_\_\_

Circle Location of Birth: Hospital Home Birthing Center How long was the labor? \_\_\_\_\_

Interventions: Epidural? Y N Forceps? Y N Vacuum Extraction? Y N

VBAC? Y N C-Section? Y N If yes, emergency or planned? \_\_\_\_\_

Any complications with delivery? \_\_\_\_\_

Has child had vaccines? Y N Was there any adverse reaction? Y N \_\_\_\_\_

### Authorization of Chiropractic Care for a Minor

I hereby authorize Dr. Van Veldhuizen at Van Family Chiropractic to administer care to my Son/Daughter as she deems necessary. I clearly understand and agree and I am personally responsible for payment of all fees charged by this office.

Signature of Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_