

WELCOME TO NORMAN FAMILY CHIROPRACTIC & WELLNESS
CHILD HISTORY FORM

Child's Name:	Age:	Date of Birth:
Parent Guardian Names:		
Address: <small>(Street, City, State & Zip)</small>		
Phone: (Home)	(Work)	(Cell)
Email Address:		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
How many siblings?		
Names & Ages of Siblings:		
Referred to Dr. Norman by:		
Purpose for visit:		
Has child been treated by any other doctor for purpose of visit?		
If yes, describe treatment given:		

Check any conditions your child has suffered from:

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

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

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Please list and describe any surgeries your child has had:

Has your child fallen from a high place?

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

List any and all medications child is taking currently, including OTC:

Describe child's normal diet on a daily basis:

Describe child's physical activity – type and how often:

Prenatal & Birth History:

Complications during pregnancy? Yes No If yes, please describe:

Ultrasounds during pregnancy? Yes No If yes, how many? Which months?

Any medications taken before or during delivery?

Alcohol/Cigarettes/Drugs during pregnancy? Yes No Was your baby full-term?

Location of Birth: Hospital Home Birthing Center How long was labor?

Interventions: Epidural Forceps Vacuum Extraction VBAC
 Planned C-Section Emergency C-Section

Any complications with delivery?

Has child had vaccines? Yes No Was there any adverse reactions?

Authorization of Chiropractic Care for a Minor

I hereby authorize Dr. Norman at Norman Family Chiropractic & Wellness to administer care to my child as he deems necessary. I clearly understand and agree, and I am personally responsible for payment of all fees charged by this office.

 X
Signature

Date