# WELCOME TO NORMAN FAMILY CHIROPRACTIC & WELLNESS

## CHILD HISTORY FORM

| | | |
|---|---|---|
| **Child's Name:** | **Age:** | **Date of Birth:** |
| **Parent Guardian Names:** | | |
| **Address:** (Street, City, State & Zip) | | |
| **Phone: (Home)** | **(Work)** | **(Cell)** |
| **Email Address:** | | |
| **Sex: □ Male □ 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:**

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

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

_____

_____

_____

# WELCOME TO NORMAN FAMILY CHIROPRACTIC & WELLNESS

## CHILD HISTORY FORM

**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**