Bruce Chiropractic

Child's Name:

Pediatrician Name:

Siblings? Names/Ages:

Reason for Visit:

Describe the reason for this visit: Condition Wellness

Is the purpose of this appointment related to: Sports Auto Fall Home Injury Other

Did this condition start: Suddenly Gradually Post Injury

What date did this condition start?

Is this problem: Occasional Frequent Constant

What makes the problem better?

What makes the problem worse?

Has this condition: Gotten worse Stayed constant Come and gone

Does this condition interfere with: Sleep Daily routine Eating Other activities

If yes, please explain:

Has this condition occurred before: Yes No

Have you seen anyone else for this condition?

Doctor's Name and Specialty:

Type of treatment/testing:

Results:

General Health History:

Does your child eat well? Yes No

Are you aware of the impact nutrition can have on your child's behavior? Yes No

Would you like more information about nutrition for your child? Yes No

Does your child have daily bowel movements? Yes No

Does your child sleep well? Yes No

Does your child sleep on his/her Stomach Side Back

Please describe his/her sleeping habits.

List any allergies your child has:

List prescription medication/supplements taken:

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Growth and Development:

Does your child have developmental or developmotor delays? Yes No

If yes, please describe:

How many times per week does your child eat fast food?

Are you aware of any food or juice allergies/intolerance?

Has your child ever taken antibiotics? (If yes, include how many times)

Has your child ever been hospitalized? Yes No

If yes, please explain:

The National Safety Council reports approx. 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, stairs, etc.)

Was this the case for your child? Yes No

If yes, please explain:

Has your child ever been in a car accident? Yes No

Has your child ever had surgery? Yes No

If yes, please explain.

Does your child have difficulty interacting with others? Yes No

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? Yes No

At wat age did your child start daycare? In-home Daycare Center

Does your child attend school/preschool? Yes No

Does your child carry a backpack? Yes No

Average number of hours of TV/Video games per week?

Are there any smokers living in the home? Yes No

Are there any indoor pets in your home? Yes No

Review of Systems:

Please mark all conditions/symptoms your child has experienced:

- **Acid reflux**
- **Bed wetting**
- **Constipation**
- **Ear infections**
- **Diarrhea**
- **Colic**
- **Asthma**
- **Poor coordination**
- **Bronchitis**
- **Sleeping difficulties**
- **Neck/Upper back pain**
- **Low back pain**
- **Difficult weight gain**
- **Learning disorders**
- **Frequent colds/coughs/flu**
- **Hyperactivity**
- **Headaches**
- **Fevers**
- **Allergies**
- **Sore throats**
- **Urinary problems**
- **Shortness of breath**