

GENERAL HEALTH HISTORY

DenverChiroCare, 86 W. 11th Avenue, Denver, CO, 80204

Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- ☐ ☐ Headaches
- ☐ ☐ Ear Infections
- ☐ ☐ Colic
- ☐ ☐ Allergies / Asthma
- ☐ ☐ Medication Side Effects
- ☐ ☐ Recurring Fevers
- ☐ ☐ Digestive problems
- ☐ ☐ Bed Wetting
- ☐ ☐ Chronic Colds/Sinus
- ☐ ☐ Other _____

Past Present

- ☐ ☐ Vision Problems
- ☐ ☐ Sleeping Problems
- ☐ ☐ Growing Pains
- ☐ ☐ Dental Problems
- ☐ ☐ Temper Tantrums
- ☐ ☐ ADHD
- ☐ ☐ Seizures
- ☐ ☐ Scoliosis
- ☐ ☐ Ever Needed Stitches

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo. _____ Total during lifetime _____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit ____/____/____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home
7. Complications During Pregnancy: ☐ No ☐ Yes Explain: _____
8. Ultrasounds During Pregnancy: ☐ No ☐ Yes How Many: _____
9. Medication During Pregnancy / Delivery ☐ No ☐ Yes List: _____
10. Cigarette / Alcohol Use during Pregnancy: ☐ No ☐ Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": ☐ No ☐ Yes, Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____

16. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Is there any other family history you want us to know? _____