

**Child's Health History Form**  
**Weinstein Chiropractic Center**  
**650 Cherrington Parkway, Moon Township, PA 15108 Ph: (412) 269-0444**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Father's Name \_\_\_\_\_  
Phone #: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_  Male  Female  
Reason for consulting our office: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Health Profile**



**Why is this form important?**

As a family chiropractic office, we focus on your child's ability to be healthy.  
Our goals First: To address the issues that brought you to this office.  
Second: To offer you and your child the opportunity of improved health potential and wellness services.

**Addressing the Issues That Brought You To Our Office**

If your child has no symptoms or complaints, and is here for wellness services, please check  ; others need to briefly describe the chief area of complaint, including the effect it has on the child.

If he/she is experiencing pain, is it:  Sharp  Dull  Comes and Goes  Travels  Constant

Since the problem started, is it:  About the same  Getting better  Getting worse?

What makes it worse? \_\_\_\_\_

It interferes with:  School  Sleep  Walking  Sitting  Hobbies  
 Other: \_\_\_\_\_

Other doctors seen for this problem:

Chiropractor: \_\_\_\_\_

Medical doctor: \_\_\_\_\_

Other: \_\_\_\_\_

List medications the child is taking or surgeries the child has had:

\_\_\_\_\_  
\_\_\_\_\_



"Can you recommend a good chiropractor?"

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

**Pregnancy:**

Were there any complications to the pregnancy? \_\_\_\_\_

Was Mom on any medications, prescriptions or over-the-counter?  Yes  No

If yes, explain: \_\_\_\_\_

Did Mom or Dad smoke during pregnancy?  Yes  No

How many ultrasounds were performed? \_\_\_\_\_

**Birth and Delivery:**

Where was the baby born?  Home  Hospital  Birthing Center  Other: \_\_\_\_\_

Was delivery:  Vaginal  C-section Were any devices used?  Forceps  Vacuum

How long was the labor? \_\_\_\_\_ How long was the delivery? \_\_\_\_\_

Was oxytocin/pitocin used?  Yes  No Was an epidural administered?  Yes  No

**Infancy:**

Was the child vaccinated?  Yes  No

Was there any prolonged use of medicines or an inhaler?  Yes  No If yes, which? \_\_\_\_\_

Did child suffer any traumas such as serious falls or car accidents?  Yes  No

Has the infant been under regular chiropractic care?  Yes  No

**Childhood years:**

Did the child have any childhood illnesses?  Yes  No Explain: \_\_\_\_\_

Does the child play youth sports?  Yes  No If yes, which sport: \_\_\_\_\_

Has the child fallen from a height over 3 feet?  Yes  No Explain: \_\_\_\_\_

Was the child involved in any car accidents?  Yes  No When? \_\_\_\_\_

Has there been any prolonged use of meds?  Yes  No Explain: \_\_\_\_\_

Has the child suffered emotional traumas?  Yes  No Explain: \_\_\_\_\_

Please give us any other health information you feel would be helpful: \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_