LOMBARDI CHIROPRACTIC FAMILY HEALTH CENTER
PRE-SCHOOL CHILD HISTORY
3 YEARS TO 5 YEARS

Patient's Name: ____________________________

Parents Names: ___________________________________

Address: __________________________________

Home Phone: ____________________________________

City, State, Zip: ___________________________

Cell Phone: ______________________________________

Sex: M F D.O.B. ___________________

Cell Carrier: ATT Verizon Sprint Other

Age: _____ SS#: ______________________

Date of last vaccination: ___________________________

Reason for Today's visit? ____

When did this problem occur? ____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

YES☐ NO☐ Does your child complain of pain or discomfort? ____

Was onset: Sudden ☐ or Gradual ☐ Is problem: Constant☐ or Intermittent☐

YES☐ NO☐ Has you child ever had this problem before? ____

YES☐ NO☐ Has your child previously been treated for this problem? ____________ By whom? _________________

YES☐ NO☐ Has your child previously had chiropractic care? ____

HEALTH HISTORY

YES☐ NO☐ Does your child ever complain of back or neck pain? ____

YES☐ NO☐ Has your child has any upper respiratory infections? How often? __________________________________

YES☐ NO☐ Has your child has asthma? ____

YES☐ NO☐ Does your child ever complain of pain in the arms or legs? ______________________________________

YES☐ NO☐ Is your child allergic to anything? ____

YES☐ NO☐ Are there any smokers in the child's home? ____

YES☐ NO☐ Does your child ever complain of headaches? ____

YES☐ NO☐ Has your child had any earaches? At what age did the first earache occur? _______________________

How frequently does your child have earaches? ____

Does your child's earache tend to occur in the same ear? Right, left, or both?

YES☐ NO☐ has your child had any other illnesses? If yes, what other illnesses? _________________________

YES☐ NO☐ Is your child presently receiving any medications? Please list? __________________________________

NUTRITION

YES☐ NO☐ Do you have any concerns about your child's diet? ____

YES☐ NO☐ Does your child have any persistent or intermittent skin rashes? __________________________________

YES☐ NO☐ Does your child eliminate stool each day? ____

YES☐ NO☐ Does your child take a multivitamin supplement? ____

YES☐ NO☐ Does your child have any food allergies? ____

For how many months was your child breastfed? ____

What does your child usually eat for breakfast? ____

What does your child usually eat for lunch? ____

What does your child usually eat for dinner? ____

What does your child usually eat for snacks? ____

What types of fast foods does your child like to eat? ____

What is your child's favorite food? ____

Trauma

YES☐ NO☐ Has your child had any recent falls or traumas? ____

YES☐ NO☐ Has your child ever fallen down stairs or fallen from any height? ______________________________

YES☐ NO☐ Has your child ever been involved in a motor vehicle accident? ________________________________

YES☐ NO☐ Has your child ever had a bone fracture or dislocation? ______________________________________

YES☐ NO☐ Has your child ever fallen from a bike, skateboard, scooter, rollerblades, etc? ___________________

YES☐ NO☐ Has your child had any other trauma or injuries? ____

YES☐ NO☐ Does your child ever bang their head repeatedly against a wall, bed, etc? _______________________

YES☐ NO☐ Natural birth? ____

Parent or Guardian Signature: ____________________________________ Date: _____________