LOMBARDI CHIROPRACTIC FAMILY HEALTH CENTER
SCHOOL-AGED CHILD HISTORY
6 YEARS AND OLDER

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? ____

YES☐ NO☐ Has this problem ever happened before? _________________________________

YES☐ NO☐ Has this problem been previously treated? By whom? ______________________

YES☐ NO☐ Has the patient had previous chiropractic care? ___________________________

HEALTH HISTORY

IN THE PAST YEAR, HAVE ANY OF THE FOLLOWING OCCURRED:

YES☐ NO☐ Back or neck pain? ____

YES☐ NO☐ Pains in the arms or legs? ____

YES☐ NO☐ Headaches? ____

YES☐ NO☐ Asthma? ____

YES☐ NO☐ Allergies? ____

YES☐ NO☐ Any problems with bedwetting? _____________________________________

YES☐ NO☐ Are there any smokers in the your/child's home? _________________________

YES☐ NO☐ Any earaches? At what age did the first earache occur? ___________________

How frequently are these earaches? _________ Is it right, left or both? ________

YES☐ NO☐ Any other illnesses? If yes, what other illnesses? _________________________

YES☐ NO☐ Presently receiving any medications? Please list: ___________________________

YES☐ NO☐ Ever been to the emergency room or hospital for evaluation or treatment?

YES☐ NO☐ Please list any surgeries: ____

YES☐ NO☐ Any other concerns about your child's health? __________________________

TRAUMA

YES☐ NO☐ Any *recent* falls or trauma? ____

YES☐ NO☐ Ever fallen down stairs or fallen from any height? ________________________

YES☐ NO☐ Ever been in a motor vehicle accident? _________________________________

YES☐ NO☐ Ever fallen from a bike, skateboard, scooter, rollerblades or similar? __________

YES☐ NO☐ Ever had a bone fracture or dislocation? ______________________________

YES☐ NO☐ Any other trauma or injuries? ____

YES☐ NO☐ Natural birth? ____

NUTRITION

YES☐ NO☐ Any concerns about the child's diet? ___________________________________

YES☐ NO☐ Does the child take a multi-vitamin supplement? ________________________

YES☐ NO☐ Does the child have any food allergies? _________________________________

YES☐ NO☐ Does the child have any persistent or intermittent disturbances? ______________

YES☐ NO☐ Does the child eliminate stool each day? ________________________________

For how many months was the child breastfed? _________________________________

What does the child usually eat for breakfast? __________________________________

What does the child usually eat for lunch? _____________________________________

What does the child usually eat for dinner? ____________________________________

What does the child usually eat for snacks? ____________________________________

What type of fast foods does the child like to eat? _______________________________

What is the child's favorite food? ____

Parent or Guardian Signature: ________________________________ **Date:** ______________