SCHOOL-AGE CHILD HISTORY

6 years and Older

Today's Date _____

Name _____ Sex: M F Date of Birth _____ Age ____

Reason for Today's Visit _____

When did this problem first occur? _____

Yes No
☐ ☐ Have you ever had this problem before? _____

Yes No
☐ ☐ Have you previously been treated for this problem? Doctor's name _____

Yes No
☐ ☐ Have you previously been to a chiropractor? When? _____

ABOUT YOUR HEALTH

In the past year have you had any of the following

Yes No
☐ ☐ Back or neck pain? _____

Yes No
☐ ☐ Pains in the legs or arms? _____

Yes No
☐ ☐ Headaches? _____

Yes No
☐ ☐ Asthma? _____

Yes No
☐ ☐ Allergies? _____

Yes No
☐ ☐ Earaches? _____

Yes No
☐ ☐ Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____

Yes No
☐ ☐ Do you ever have a problem with bedwetting? _____

Yes No
☐ ☐ Have you ever been in a motor vehicle accident? _____

Yes No
☐ ☐ Have you ever had any broken bones? _____

Yes No
☐ ☐ Have you ever had any surgeries? _____

Yes No
☐ ☐ Are you at present taking any medications? _____

Yes No
☐ ☐ Do you have any other health problems? _____

_____

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ABOUT YOUR LIFESTYLE

What grade are you in at school? _____

How do you carry your school books? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET

What do you usually eat for Breakfast? _____

_____

What do you usually eat for Lunch? _____

_____

What do you usually eat for Dinner? _____

_____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or colas do you drink each day? _____

How often do you eat fast food items? _____