Care Chiropractic
Health & Rehab

PRE-SCHOOLER PORTRAIT

1-5 YEARS

Child's Name: _____ AHC #: _____ Date: _____

Address: _____ Home Phone #: _____

Mother's Name: _____Work Phone # : _____Cell #:_____

Father's Name: _____Work Phone # : _____Cell #:_____

Birth Date: D/ ___ M/ ___ Y/ ___ Age: ___ Sex: ❑ M ❑ F Weight: _____ Height: _____

Reason for Child's visit:_____

HEALTH HISTORY

Please mark any of the following that apply:

Childhood Diseases:

❑ Measles ❑ Mumps ❑ Rubella ❑ Chicken pox ❑ Whooping cough

❑ Rubeola ❑ Colic ❑ Other: _____

Has this child every suffered from:

❑ Asthma	❑ Ear infections	❑ Hyperactivity	❑ Broken bones
❑ Difficulty breathing	❑ Allergies	❑ Back/Neck Problem	❑ Arthritis
❑ Tuberculosis	❑ Dizziness	❑ Arm/Leg Problems	❑ Neuritis
❑ Colds/Flu	❑ Digestive Disorder	❑ Headaches	❑ Diabetes
❑ Throat infections	❑ Convulsion	❑ "Growing" pains	❑ Heart trouble
❑ Poor appetite	❑ Paralysis	❑ Bed wetting	❑ Hypertension
❑ Sinus infections	❑ Walking Problems	❑ Joint Problems	❑ Anemia
❑ Chronic ear aches	❑ Rheumatic fever	❑ Cancer	

Fill in the following that apply:

Surgery: _____ Medications: _____ Accidents: _____

Congenital anomalies/defects: _____

Immunization History: _____

Name of Pediatrician or General Practitioner: _____

Last visit: _____

Has your child been treated on an EMERGENCY basis? ❑ Yes: _____

❑ No

Would you describe your child's health as:

❑ very robust ❑ very good ❑ average

❑ poor ❑ sickly

Has there been a recent change in your child's energy level? □ **Yes** □ **No**

If yes, is it:

Higher ❑

Lower ❑

Is there anything else that we should know that has not been addressed? _____

_____

_____

_____

_____ _____ _____

Parent's Printed Name Parent's Signature Date