



# MATZNER FAMILY CHIROPRACTIC



## Child Health History Form

We are happy you have chosen to have your child's spine checked. Many types of stress (physical, mental, and chemical) can interfere with you child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions!

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Pt. # \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent's work phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Names and Ages of Siblings \_\_\_\_\_

Reason for consulting our office \_\_\_\_\_

Social Security # \_\_\_\_\_

Previous Chiropractic Care? Y / N If yes, with whom? \_\_\_\_\_

How long was care received? \_\_\_\_\_ Last Check-up \_\_\_\_\_

Insured's SS# \_\_\_\_\_

Place of Work \_\_\_\_\_ Date of Birth \_\_\_\_\_

### CIRCLE APPROPRIATELY:

Birth Place: Home / Birth Center / Hospital

Type: Vaginal / C-section

Procedures: Forceps / Vacuum Extraction

Was delivery long: Y / N Was delivery difficult? Y / N Labor Induced? Y / N

Epidural? Y / N Pain Medication? Y / N

Was baby breech/in utero-constraint? Y / N

Was baby breast fed? Y / N Duration \_\_\_\_\_

Which sports does/did your child participate in?

None / Soccer / Football / Gymnastics / Cheerleading / Karate / Basketball / Dance

Other(s) \_\_\_\_\_

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc...) during the first year of life. Has this happened to your child? Y / N Comments \_\_\_\_\_

List any other falls or accidents \_\_\_\_\_

OVER

Check any of the following conditions your child has suffered from:

(Circle 'P' if in the distant past, circle 'R' if in the past 6 months)

- |                          |                        |                          |
|--------------------------|------------------------|--------------------------|
| P / R Ear Infections     | P / R Scoliosis        | P / R Seizures           |
| P / R Chronic colds      | P / R Asthma/Allergies | P / R Digestive Problems |
| P / R Headaches          | P / R ADD/ADHD         | P / R Recurring Fevers   |
| P / R Growing/Back Pains | P / R Colic            | P / R Bed Wetting        |
| P / R Constipation       | P / R Head Banging     | P / R Other: _____       |

List date and year of any surgeries or hospitalizations \_\_\_\_\_

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

**MEDICATION**

How many rounds of antibiotics has your child taken in the last 6 months? \_\_\_\_\_

Lifetime \_\_\_\_\_

Present prescription  
drugs \_\_\_\_\_

Past prescription  
drugs \_\_\_\_\_

Over the counter drugs (past 6 months) \_\_\_\_\_

**FINANCIAL INFORMATION**

Person responsible for account: \_\_\_\_\_

Are you planning to use some type of insurance? Y / N

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**AUTHORIZATION FOR CARE OF A MINOR**

I hereby authorize Matzner Family Chiropractic and whomever they may designate to administer care, as they deem necessary to my son/daughter.

My presence is / is not necessary for care to be rendered (circle one).

Signed: \_\_\_\_\_

Today's Date: \_\_\_\_\_