Baker Borski Chiropractic

PRE-SCHOOL CHILD HISTORY

(2 years to 5 years)

Today's Date_____

Child's Name_____ Sex: M F Date of Birth_____

Age_____

Reason for Today's Visit_____

YES NO Does your child complain of pain or discomfort? If yes, when did this occur?_____

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

YES NO Has your 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? Previous chiropractor_____

Health History

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

YES NO Does your child ever complain of pains in the legs or arms?_____

YES NO Does your child ever complain of headaches?_____

YES NO Has your child had asthma?_____

YES NO Is your child allergic to anything?_____

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

YES NO Has your child had any earaches? At what age did the child's first earache occur?____

How frequently does your child have earaches?_____

In which ear do your child's earaches usually occur? ☐Right ☐Left ☐Both

YES NO Is your child presently taking any prescribed medication?_____

YES NO Do you have any other concerns about your child's health?_____

_____

_____

Please list any other illness which have been a concern for your child_____

_____

Please list any surgeries your child has had_____

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? _____