## Did your child suffer any health problems, such as:

| | | | | | |
|---|---|---|---|---|---|
| Headaches | ☐ Yes | ☐ No | Meningitis | ☐ Yes | ☐ No |
| Allergies | ☐ Yes | ☐ No | Diarrhea | ☐ Yes | ☐ No |
| Ear Problems | ☐ Yes | ☐ No | Constipation | ☐ Yes | ☐ No |
| Sleeping Disorders | ☐ Yes | ☐ No | Colic | ☐ Yes | ☐ No |
| Breathing Problems | ☐ Yes | ☐ No | Rashes | ☐ Yes | ☐ No |
| Fatigue | ☐ Yes | ☐ No | Milk or Lactose Intolerance | ☐ Yes | ☐ No |
| Irritability | ☐ Yes | ☐ No | Bed Wetting | ☐ Yes | ☐ No |
| Hyperactivity | ☐ Yes | ☐ No | Digestive Problems | ☐ Yes | ☐ No |
| Frequent Colds | ☐ Yes | ☐ No | Other: _____ | | |
| Flu | ☐ Yes | ☐ No | _____ | | |
| Bloody Noses | ☐ Yes | ☐ No | _____ | | |

## Regarding your child today:

Is your child accident prone: ☐ Yes ☐ No

Has the child had any falls down steps? ☐ Yes ☐ No

Has your child ever fallen from heights over 2 feet? ☐ Yes ☐ No

Has your child ever been involved in a motor vehicle accident? ☐ Yes ☐ No

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No

Does your child suffer from:

| | | |
|---|---|---|
| Allergies | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |

Has your child ever had any broken bones or sprain injuries? ☐ Yes ☐ No

Is your child on any medication? ☐ Yes ☐ No

Has your child had a scoliosis examination by an approved scoliosis determination procedures clinic? ☐ Yes ☐ No

| | | |
|---|---|---|
| Is your child hyperactive? | ☐ Yes | ☐ No |
| Have learning disorders? | ☐ Yes | ☐ No |
| Sleeping difficulty? | ☐ Yes | ☐ No |
| Poor posture? | ☐ Yes | ☐ No |

Does your child have any problem associating with friends? ☐ Yes ☐ No

Is your child nervous, or has anyone suggested that your child was nervous? ☐ Yes ☐ No

Does your child show any signs of nervousness, twitching or excessive talking to themselves? ☐ Yes ☐ No

If you could improve one aspect of your child's health or behavior, what would it be?_____

_____

_____

**DO NOT WRITE BELOW THIS LINE**

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature