

Pre-School Child History
3 Years to 5 years

Child's Name _____ Today's Date _____

Has your child had previous chiropractic care? Yes No When? _____

How many medical doctor office visits did your child have last year? _____ Your family? _____

A Few More Health Questions:

Yes No Does your child ever complain of pain or discomfort?

If yes, when did this begin? _____

Was the onset Sudden or Gradual

Yes No Has your child ever had this problem before? When? _____

Yes No Has your child previously been treated for this problem? By Whom? _____

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

Please list any other illnesses which have been a concern for your child: _____

Yes No Do you have any other concerns about your child's health? _____

Lifestyle Information:

Does your child get 30 minutes of continuous physical activity each day? Yes No

What type of activity? _____

Is the child's diet healthy? Yes No

How would you describe the diet? _____

How much water does your child drink each day? _____

The statements made on this form are accurate to the best of my recollection and I grant permission for this office to examine my child and evaluate their health.

Parent/Guardian Signature

Date