

School-Age Child History 6 years and older

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 get earaches? _____

Yes No Does your child ever have a problem with bedwetting? _____

Yes No Has your child ever been in a motor vehicle accident? When? Please describe _____

 Yes No Has your child ever had any broken bones? Please list _____

Yes No Has your child ever had any surgeries? (include dates) _____

 Yes No Does your child have any other health problems? _____

About Their Lifestyle:

What grade is the child in school? _____

How does he/she carry their school books? _____

How heavy is their school book bag? _____

What sports do they play? _____

What hobbies do they have? _____

How many hours each day do they spend using a computer? _____

How many hours each day do they watch TV? _____

How often do they play video games? _____

On average, how many hours of sleep do they get each night? _____

Are there any smokers in your family? _____

Does your child feel stressed out? _____

Does your child have trouble reading the board in class? _____

Does your child ever have blurred vision? _____

Does your child wear glasses or contact lenses? _____

Does your child sometimes get headaches when they read? _____

Child's Name _____ Today's Date _____

About Their Diet & Exercise:

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child you usually eat for dinner? _____

What snacks does your child have after school? _____

What is your child's favorite food? _____

How much water does your child drink each day? _____

How many sodas or colas does your child drink each day? _____

How often does your child eat fast food items? _____

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

What type of activity? _____

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