



Child History Form

Name _____ Birth Date ___/___/___ Today's Date ___/___/___

Address _____ City _____ State _____ Zip _____

SS#: _____-_____-_____ Male _____ Female _____ Height _____ Weight _____

Name of Dad _____ Name of Mom _____

Home # (____) _____ Cell # (____) _____ Email _____

Parents Employment _____ Occupation _____

Work # (____) _____ Referred By _____

In case of emergency contact _____ Relation to patient _____

Please check if you are here for the following: ___ Family Care ___ Wellness ___ Other

Reason for consulting our office? _____

Names of other Doctors seen for this? _____ Name of Pediatrician _____

Circle all of the following that your child has had during the past SIX MONTHS:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Stomach aches	Reoccurring Fever	Growing/Back Pains	Bed Wetting
Car Crash	Temper Tantrums	ADD/ADHD	Trouble Sleeping	Colic
Constipation	Fatigue	Gas	Sinus Problems	Poor Posture

Family History/Health Problems _____

Number of Doses of Antibiotics Your Child Has Taken:

During Last Six Months _____ During Lifetime _____

Number of Doses of Other Prescription or Non-Prescription Drug (including Tylenol, Aspirin)

Taken: During Last Six Months _____ During Lifetime _____

Vaccine History _____

Childhood Diseases

Chicken Pox	Age _____	Mumps	Age _____
Rubella	Age _____	Whooping Cough	Age _____
Measles	Age _____	Other	Age _____

Prenatal History

Name on Obstetrician/Midwife _____

Complications During Pregnancy? Y / N List _____

Ultrasounds During Pregnancy? Y / N How Many? _____

Medications During Pregnancy? Y / N List _____

Tobacco/Alcohol During Pregnancy? Y / N List _____

Genetic Disorders or Disabilities? Y / N List _____

Birth Place? ___ Hospital ___ Birthing Center ___ Home ___ Other _____

Birth Intervention: Forceps ___ Vacuum Extraction ___ Caesarian Section ___ Planned Y / N

Birth Weight ___ lbs. Birth Length ___ in. APGAR Scores ___ (1 Min) ___ (5 Min) ___

Feeding History

Breast Fed? Y / N How long? _____ Formula Fed? Y / N How long? _____ Type? _____

Introduced to Solids at ___ Months Food/Juice Allergies or Intolerances? Y / N List _____

Developmental History

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a chiropractor for early detection and correction of vertebral subluxation (nerve interference). At what age was your child able to:

___ Respond to Sound ___ Respond to Visual Stimuli ___ Hold Head Up ___ Sit up

___ Roll Over ___ Crawl ___ Stand Alone ___ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life. Has this happened to your child? Y / N

Is/has your child been involved with any high impact or contact type sports (Soccer, Football, Gymnastics, Baseball, etc.) Y / N List: _____

Has your child ever been involved in a car accident? Y / N Date: _____ Describe: _____

Has your child ever been seen on an emergency basis? Y / N Describe: _____

Other Traumas or Surgeries: _____

AUTHORIZATION FOR CARE OR A MINOR

I hereby authorize Bauer Chiropractic & Muscle Therapy and Dr. Todd Bauer to administer care to my child, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by Bauer Chiropractic & Muscle Therapy.

Signature

Date