Generations Chiropractic and Wellness

Branch of Heiden Chiropractic Inc.

608-781-9555

Child New patient

Name_____ Date_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past.

☐ Vision Problems ☐ Pink Eye ☐ Headaches ☐ Ear Problems
☐ Sleeping Disorders ☐ Tubes in the Ears ☐ Irritability
☐ Attention Problems ☐ Frequent Colds ☐ Allergies
☐ Colic ☐ Breathing Problems ☐ Digestive Issues ☐ Asthma
☐ Hyperactivity ☐ Constipation ☐ Bed Wetting ☐ Loss of appetite
☐Change in sleeping habits ☐ Scoliosis ☐ Seizures
☐ Skin problems
☐Other_____
_____

MOTHER'S PREGNANCY & LABOR

Approximately how long did labor last?
_____Hours
Was Labor Chemically Induced? ☐ Y ☐ N
Was Labor Doctor Assisted? ☐ Y ☐ N
Was a C-Section performed? ☐ Y ☐ N
Were forceps or vacuum extraction used? ☐ Y ☐ N
Did the delivery doctor pull or twist the baby during delivery? ☐ Y ☐ N
Was the delivery Premature? ☐ Y ☐ N

Check any of the following if the child experienced it immediately after birth.

☐ Jaundice ☐ Respiratory Problems ☐ Feeding Problems
☐ Displaced or Broken Joints ☐ Other Condition(s)

NEURODEVELOPMENTAL DISORDERS

☐ Autism ☐ Asperger's ☐ ADD/ADHD ☐ Rett Syndrome
☐ Learning Disorder