
List any previous medication(s), for what condition, and the number of times it was prescribed: _____

List any emergency/hospital visits: _____

As a baby/toddler (birth-4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from change table/crib | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Involved in a car accident | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Play in "Jolly Jumper" | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other _____ |

As a young child (5-12 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from tree/playground equipment | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Other _____ |

SYMPTOMS AND ILL HEALTH

As a child or adolescent, has your child experienced any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck/back pains | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Other: _____ | |

Present reason for consulting our office:

- Maximizing personal and / or family health potential?
- Correction and prevention of an existing problem? *Please fill out the information below.*

If your child has symptoms or a complaint, briefly describe the problem here. _____

How and when did this problem start? _____

The problem is: Constant _____ Comes & Goes _____ Radiates/Travels (*where?*) _____

If he/she is experiencing pain, is it: Sharp ___ Dull ___ Throbbing ___ Aching ___ Shooting ___ Nagging ___

What aggravates the condition / pain? _____

What relieves the condition / pain? _____

Please describe any past or current treatment(s) and results: _____

Is there anything else you would like us to know? _____
