THE CONNECT
CHIROPRACTIC

1210 6th St. Ste. #103

Nevada, Iowa 50201

GENERAL HEALTH HISTORY

Patient Name_____

Mark the conditions that apply to you.

Past	**Present**		**Past**	**Present**
□	□	Headaches	□	□ Vision Problems
□	□	Ear Infections	□	□ Sleeping Problems
□	□	Colic	□	□ Growing Pains
□	□	Allergies / Asthma	□	□ Dental Problems
□	□	Medication Side Effects	□	□ Temper Tantrums
□	□	Recurring Fevers	□	□ ADHD
□	□	Digestive problems	□	□ Seizures
□	□	Bed Wetting	□	□ Scoliosis
□	□	Chronic Colds/Sinus	□	□ Ever Needed Stitches

Other

_____

1. List any medications being taken: _____

2. Number of courses of Antibiotics child has taken in the last 6 mo. __ Total during lifetime_____

3. Name of Pediatrician and Other Doctors:

_____

4. Date of Last Visit _____/_____/_____ Reason:

_____

5. Name of Obstetrician/Midwife:

_____

6. Location of Birth: Hospital Birthing Center Home

7. Complications During Pregnancy: No Yes Explain:

_____

8. Ultrasounds During Pregnancy: No Yes How Many: _____

9. Medication During Pregnancy / Delivery No Yes List:

_____

10. Cigarette / Alcohol Use during Pregnancy: No Yes

11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": No Yes
Name_____

PAST HISTORY

12. List any past auto collisions: _____
Was any care received? _____

13. List any past falls bumps bruises: _____
Was any care received? _____

14. List any past sport, recreational, or home injuries:_____
_____

15. Please describe any past conditions and treatment received:
_____
_____
_____

16. Please list any past hospitalizations and surgeries:
_____
_____

FAMILY HISTORY

Father's side: □ heart disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis
□ Other_____
Mother's side: □ heart disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis
□ Other_____
Is there any other family history you want us to know?
_____