

HAS YOUR CHILD EVER SUFFERED FROM:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Other: _____ |

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard or skates |
| <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Other: _____ |

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain _____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

- | | | |
|-------------------------------|--------------------------------|----------------------|
| ____ Heart Disease | ____ Diabetes | ____ Stroke |
| ____ Cancer | ____ High / Low blood pressure | ____ Asthma |
| ____ Gastrointestinal disease | ____ Memory/mood disorder | ____ Thyroid problem |

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness _____ Check-up _____ Other: _____
 _____ Pain/Discomfort; explain _____
 _____ Injury; explain _____

If due to Pain/Discomfort/Injury, please fill out:

- Onset of Problem: Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden
- Ever had this problem before? No Yes If yes when? _____
- Any bowel or bladder problems since this problem began?: No Yes (Describe): _____
- Any medication taken for this problem? No Yes: _____
- Have you seen any other doctors for this problem? No Yes: _____
- How is this problem NOW: Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

I understand that I am directly and fully responsible to LifeSource Health & Wellness Cntr. all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must retained these films for a period of no less than 5 years

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

Parent's or Legal Guardian's Signature

Date