Wellness for You NOW Chiropractic **Dr. Joseph Manza, DC, CACCP**

We are honored and blessed that you have chosen our office to serve your family.
Please know that we will care for your children with the greatest respect and tenderness.

Toddler to Pre-school Child History 1-5 years

Child's Name_____Birthdate_____ Sex: M F

Address_____City_____Zip_____

Parents' Names_____

Parent's Phone_____Work#_____

Parent's email_____

Siblings and ages_____

Whom may we thank for referring you to our office? _____

REASON FOR TODAY'S VISIT: _____

Does your child complain of pain or discomfort? Yes No If yes, when did this occur? _____

Was the onset: ____ Sudden ____ Gradual Is the problem: ____ Constant ____ Intermittent

Has your child ever had this problem before? Yes No If Yes:_____

Has your child previously been treated for this problem? Yes No By whom? _____

Has your child previously had chiropractic care? Yes No By whom? _____

NUTRITION

Do you have any concerns about your child's diet? Yes No If Yes:_____

Does your child have any food allergies? Yes No If Yes:_____

Does your child have any persistent or intermittent skin rashes? Yes No If Yes:_____

Does your child take vitamin supplements? Yes No If Yes:_____

Does your child eliminate stools each day? Yes No If No, How often:_____

Does your child have any digestive disturbances? Yes No If Yes:_____

For how long was your child breast-fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____ _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

What type, and how often does your child eat fast food? _____

How much cow's milk does your child drink/day? _____

TRAUMA

Place of birth: ___ Home ___ Birthing Center ___ Hospital
Provider: ___ Midwife ___ OB-Gyn. Other_____
Type of Birth: ___ Vaginal ___ C-section ___ emergency ___ scheduled
Was the birth: ___ Doctor assisted ___ Forceps
___ Vacuum Extraction ___ Twisting/Pulling Other_____
Was your child breech? Yes No Other Malposition?_____
Was there any trauma to your newborn? Yes No If yes, please describe _____
_____

Has your child had any recent falls or trauma? Yes No
If yes, please describe: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? Yes No
If Yes_____

Has your child ever fallen down stairs or fallen from any height? Yes No If Yes_____

What sporting activities does your child engage in?

___ Soccer ___ Football ___ Gymnastics ___ Hockey ___ Lacrosse ___ Swimming/Diving
___ Dance ___ Wrestling ___ Baseball/Softball ___ Martial Arts ___ Basketball ___ Field Hockey

Other_____

Has your child ever been in a motor vehicle collision or near miss? Yes No If Yes:_____

Has your child had any other trauma or injuries? Yes No If Yes:_____

Has your child ever had a bone fracture/dislocation Yes No If Yes:_____

HEALTH HISTORY

In order to better understand your child's level of health, please check any of the following body signals you have noticed your child currently or previously displaying.

___ Colic ___ Headaches ___ Digestive problems ___ Irregular Sleeping Patterns
___ Ear Infections ___ Seizures ___ Bed Wetting ___ Learning Disorders
___ Allergies ___ Tantrums ___ Chronic colds ___ Emotional Disorders
___ Asthma ___ Night Terrors ___ Chronic Infections ___ ADD/ADHD or Autism Spectrum

Other: _____

Does your child ever complain of back or neck pain? Yes No If Yes:_____

Does your child ever complain of pains in the arms and legs? Yes No If Yes:_____

Does your child ever complain of headaches? Yes No If Yes:_____

Has your child had asthma? Yes No If Yes:_____

Is your child allergic to anything? Yes No If Yes:_____

Are there any smokers in the child's home? Yes No

Has your child had any earaches? Yes No At what age did the first earache occur? _____

How frequently does your child have earaches?_____

How many courses of antibiotics has your child been exposed to? _____

Has your child had any other illnesses? Yes No If Yes:_____

Is your child presently receiving any medications? Yes No If Yes:_____

Has your child ever been to a hospital or emergency room for evaluation or treatment? Yes No If Yes:_____

Has your child recently been vaccinated? Yes No

Do you have any other concerns about your child's health? Yes No If Yes:_____

QUALITY OF LIFE AND CURRENT HEALTH STATUS

How do you grade your child's physical health? Excellent Good Fair Poor

How do you grade your child's emotional/mental health? Excellent Good Fair Poor

How do you grade your child's overall "quality of life"? Excellent Good Fair Poor

Do you believe your child is expressing their full health potential? Yes No If no, why? _____

How can we/chiropractic help your child achieve their optimum health? _____

_____

Thank you for choosing Wellness for You NOW Chiropractic!
We know there is no more precious gift than the health and happiness of your child.