

GENERAL HEALTH HISTORY Swearingen Family Chiropractic – 23295 US-14, Richland Center, WI 53581

Patient Name _____ *Mark the conditions that apply to you.*

Past	Present		Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches		<input type="checkbox"/>	<input type="checkbox"/> Vision Problems
<input type="checkbox"/>	<input type="checkbox"/> Ear Infections		<input type="checkbox"/>	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/>	<input type="checkbox"/> Colic		<input type="checkbox"/>	<input type="checkbox"/> Growing Pains
<input type="checkbox"/>	<input type="checkbox"/> Allergies / Asthma		<input type="checkbox"/>	<input type="checkbox"/> Dental Problems
<input type="checkbox"/>	<input type="checkbox"/> Medication Side Effects		<input type="checkbox"/>	<input type="checkbox"/> Temper Tantrums
<input type="checkbox"/>	<input type="checkbox"/> Recurring Fevers		<input type="checkbox"/>	<input type="checkbox"/> ADHD
<input type="checkbox"/>	<input type="checkbox"/> Digestive problems		<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Bed Wetting		<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Chronic Colds/Sinus		<input type="checkbox"/>	<input type="checkbox"/> Ever Needed Stitches
<input type="checkbox"/>	<input type="checkbox"/> 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? _____