Tree of Life CHIROPRACTIC INC.

1804 3rd Avenue
Rock Island, IL 61201
309.786.8733

Name	Date
Parent/Guardian	

Child History

Please complete this health history questionnaire as thoroughly as possible. If you do have any questions about what is being ask, please consult a Tree of Life team member.

Describe the child's current health condition_____
_____
_____
_____

Why are you seeking chiropractic care _____
_____
_____

These questions pertain to the birthing process. Please check **YES** or **NO** below

Yes	No	
□	□	Natural Vaginal
□	□	C-Section
□	□	Vacuum Extraction
□	□	Forceps
□	□	Hospital
□	□	Birthing Center
□	□	Home Birth
□	□	Epidural
□	□	Breech
□	□	Underwater

List any complications during pregnancy: _____
_____
_____
_____

List any complications during the labor/delivery process: _____
_____
_____
_____

List all significant accidents/injuries the child has sustained: _____
_____
_____
_____

List all surgeries or unscheduled doctor visits: _____
_____
_____

Eating Habits of your child

□	□	Breastfed	How long? _____
□	□	Good Appetite	
□	□	On specific diet	Describe _____
□	□	Eating on a schedule	
□	□	Does he/she eat a balanced meal	
□	□	Act hungry but will not eat	
□	□	Have difficulty holding food/liquid down	
□	□	Teething	How many teeth _____

Please list the following

Vaccines with dates

_____ _____
_____ _____
_____ _____

Medications
(Prescription / Over the Counter)

_____ _____
_____ _____
_____ _____

Please check to indicate if your child has **ever** experienced any of these conditions

□ Allergies	□ Diabetes	□ Leg Problems
□ Anemia	□ Diarrhea	□ Muscle Jerking
□ Arm Problems	□ Digestion Problems	□ Neck Problems
□ Asthma	□ Dizziness	□ Orthopedic Problems
□ Backaches	□ Fainting	□ Paralysis
□ Bed Wetting	□ Frequent Infections	□ Rheumatic Fever
□ Behavior problems	□ 'Growing Pains'	□ Rupture/hernias
□ Broken Bones	□ Heart Trouble	□ Sinus Problems
□ Chronic Earaches	□ Hyperactivity	□ Skin Problems
□ Colds/Flu	□ Hypertension	□ Sugar Levels
□ Constipation	□ Jaundice	□ Tuberculosis
□ Convulsions	□ Joint Problems	□ Walking Problems

Answer the following. Explain if needed.

Yes	No	
□	□	Have you ever observed your child pulling his/her hair _____
□	□	Have you observed your child pulling on his/her ears _____
□	□	Does your child focus on you or objects and tracks with both eyes _____
□	□	Does your child have red rings on inside of eyes _____
□	□	Does your child have excess drooling _____
□	□	Does your child have a persistent cough, wheezing, congestion _____
□	□	Does you child have cold hands or feet _____
□	□	Does your child have sudden mood swings _____
□	□	Does your child cry for no reason _____
□	□	Does your child have outburst of anger _____
□	□	Does your child have any skin conditions/lesions _____
□	□	Does your child sleep well at night _____
□	□	Does your child engage in physical activity _____

How would you rate your child's current health? (Please circle)

Excellent Very Good Good Fair Poor

_____ _____

Parent/Legal Guardian Signature/Relationship with child Date