MUSKEGO Health & Wellness CENTER

S69 W15689 Janesville Rd., Muskego, WI 53150
(414) 422-1203-www.muskegochiropractor.com

PRE-SCHOOL CHILD HISTORY

3 years to 5 years

Today's Date_____

Child's Name: _____Sex: M F Date of Birth_____ Age____

Reason for Today's Visit:_____

Yes No

❑ ❑ Does your child complain of pain or discomfort? If yes, when did this occur?_____

Was onset Sudden ❑ or Gradual ❑ Is problem Constant ❑ or Intermittent ❑

Yes No

❑ ❑ Have you ever had this problem before? _____

❑ ❑ Have you previously been treated for this problem? By whom? _____

❑ ❑ Have you previously been to a chiropractor? Previous Chiropractor?_____

HEALTH HISTORY

Yes No

❑ ❑ Does your child ever complain of back or neck pain?_____

❑ ❑ Does your child ever complain of pains in the legs or arms? _____

❑ ❑ Does your child ever complain of headaches? _____

❑ ❑ Has your child had asthma?_____

❑ ❑ Is your child allergic to anything? _____

❑ ❑ Are there any smokers in the child's home?_____

❑ ❑ Has your child had any earaches? At what age did the child's first earache occur _____

How frequently does your child have earaches? _____

In which ear do your child's earaches usually occur? Right ❑ Left ❑ Both ❑

❑ ❑ Is your child presently taking any prescribed medication? _____

Please list any other illness which have been a concern for your child _____

_____

Please list any surgeries your child has had _____

_____

Yes No

❑ ❑ Do you have any other concerns about your child's health? _____

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TRAUMA

Yes No

- ❑ ❑ Has your child had any recent falls or trauma?
  Describe the trauma and the date it occurred _____
- ❑ ❑ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____
- ❑ ❑ Has your child ever fallen down stairs or fallen from a significant height? _____
- ❑ ❑ Has your child ever been in a motor vehicle collision or near-miss? _____
- ❑ ❑ Has your child ever had a bone fracture or joint dislocation? _____
- ❑ ❑ Has your child ever had any other trauma or injuries? _____
- ❑ ❑ Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

NUTRITION

Yes No

- ❑ ❑ Do you have any concerns about your child's diet? _____
- ❑ ❑ Does your child have any food allergies? _____
- ❑ ❑ Does your child have any persistent or intermittently occurring skin rashes? _____
- ❑ ❑ Does your child take vitamin supplements? _____
- ❑ ❑ Does your child eliminate stools each day? _____

For how many months 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? _____
How much cow's milk does your child drink each day? _____
What is your child's favorite food? _____
What type of fast foods does your child like to eat? _____