Corbett Chiropractic
& Health Enhancement

Child's Health History

Patient Name _____ Date _____

Has your child had chiropractic care? ___Yes ___No If yes, doctor's name_____

Date of last adjustment _____

Currently under medical care ___Yes ___No Reason(s)_____

Reason for consulting our office _____

Please check all that apply

_____ Illness during pregnancy
_____ Tobacco or alcohol during pregnancy
_____ Pulling or twisting during delivery
_____ C-Section
_____ Vaccinations
_____ Colic
_____ Sleeping problem
_____ Other falls or injuries
_____ Ear infections
_____ Digestive problems
_____ Poor nutrition
_____ Sports injury
_____ Prescription drug use
_____ Ever Hospitalize
_____ Any major illness
_____ Limited exercise

_____ Drugs or medicine during pregnancy
_____ Labor chemically induce
_____ Forceps/vacuum extraction
_____ Premature delivery
_____ Jaundice treatment
_____ Eating or nursing problems
_____ Falls in the first year of life
_____ Respiratory problems
_____ Allergies/Asthma
_____ Hyperactivity
_____ Auto accident or injury
_____ Family/home stress
_____ Non-prescription drug use
_____ Surgery
_____ Recurring illness
_____ Other health related problems

Please use this space to provide more information regarding the checked items from above:

_____
_____
_____
_____

Please check the choice that most closely describes the goals for your child's health and wellbeing.
_____ I am only concerned about relief of a particular symptom.
_____ I am only concerned about relief of a particular symptom and preventing its return.
_____ I want optimal health and wellbeing on every level for my child.

I hereby authorize Dr. Corbett to provide chiropractic care as may be deemed necessary to my child.

_____ _____
Signature Date