

**COMPLETE THIS PAGE FOR CHILDREN 4-8 YEARS OF AGE**

**CHILD'S CURRENT HEALTH**

DURING PREGNANCY DID YOU USE:  
 DRUGS/MEDICATIONS       TOBACCO/ALCOHOL  
 IF YES, PLEASE EXPLAIN:

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DESCRIBE YOUR DELIVERY:  
 LABOR WAS CHEMICALLY INDUCED     LABOR WAS DOCTOR ASSISTED  
 C-SECTION DELIVERY                     FORCEPS/VACUUM EXTRACTION  
 DOCTOR PULLED OR TWISTED BABY    PREMATURE DELIVERY  
 PLEASE EXPLAIN:

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DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

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HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?     YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER BEEN HOSPITALIZED?     YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?  YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER HAD SURGERY?             YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?  
 YES       NO  
 PLEASE EXPLAIN:

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HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT?  
 YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)  
 YES       NO  
 PLEASE LIST:

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WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

**CHILD'S HEALTH HISTORY**

**INSTRUCTIONS:** Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> UPSET STOMACH
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> LEARNING DISORDERS	
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> NERVOUSNESS	

**NUTRITION**

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE FOOD ALLERGIES?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURRING SKIN RASHES?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD ELIMINATE STOOLS EACH DAY?  
 YES       NO  
 PLEASE EXPLAIN:

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WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?

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WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?

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WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?

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WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?

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HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?