

PALMER CENTER FOR NATURAL HEALING (480) 443-2584
YOUR CHILD'S HEALTH HISTORY

YOUR NAME _____ DATE _____

YOUR CHILD'S NAME _____ MALE _____ FEMALE _____ AGE _____

OFFICE USE ONLY

Consultant's Initials _____

HEALTH HISTORY

The general state of their health is:

(Excellent _____) (Good _____) (Average _____) (Fair _____) (Poor _____)

Describe their energy level on average from 1 -10 (10 being highest): _____

When during the day is their energy the best? _____ Worst? _____

What is their current approximate weight? _____ Height? _____ Weight 1 yr ago? _____

What's been their maximum weight? _____ Minimum _____

How were you referred to us? _____

Any previous chiropractic care? Y / N If so, who and when? _____

Rate your pregnancy on a scale of 1-10 (1 being a breeze and 10 being horrendously difficult) _____ and why _____

Were you ill during your pregnancy? _____ If so, what? _____

Did you take antibiotics during pregnancy? _____ If so, how many courses? _____ For what? _____

Was the delivery vaginal _____ C-Section _____ How many hours did the birth take _____

Rate the birth process using the same scale _____ and why _____

Did your child ever fall off of the bed or changing table as an infant? _____ Describe _____

Do you notice that they have their head turned one way more than the other while sleeping on their back or in their car seat? If so, which way? Right _____ Left _____

Did you breastfeed? _____ If so, for how long? _____

At what age did they begin to walk? _____

Were they vaccinated? _____ If so, how many times _____ and against how many different diseases? _____

Give us a history of illnesses that they have had starting with their most common or severe to the least common or severe (i.e. skin, eye-ear-nose-throat, digestion or bowels, lungs, etc.):

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Have they ever taken antibiotics? _____ If so, how many courses and at what ages? _____

List any behavioral issues they have had:

- 1) _____
- 2) _____
- 3) _____

Have they had any learning challenges? _____ If so, what? _____

List the falls or injuries that they have had:

- 1) _____ Age _____
- 2) _____ Age _____
- 3) _____ Age _____
- 4) _____ Age _____
- 5) _____ Age _____

What is their PRIMARY COMPLAINT? (Give as much detail as possible)

Patient Name _____
Date _____

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How Long Ago Was The Onset?: _____
Have they Ever Had Similar Symptoms Before? Y / N When: _____
Do You Know What Caused This? (TRAUMA / ACCIDENT / GRADUAL ONSET / DON'T KNOW)
Is The Pain; (CONSTANT / FREQUENT / OCCASIONAL)
Is The Condition; (GETTING BETTER / WORSE / STAYING THE SAME)
Does The Pain Radiate Or Refer Anywhere? _____
Does Coughing / Sneezing Increase The Pain? _____
What Have You Done For Treatment? (ICE / HEAT / NSAIDS / MEDICATIONS) Has That Helped? Y / N
What makes it worse? _____
Have You Seen Any Other Health Care Providers For This Condition? Y / N (Including naturopathic physician, acupuncturist, or other alternative health practitioner for their current problem)
If Yes; WHO _____ WHEN _____ TYPE OF PHYSICIAN _____
What was the treatment and the results? _____
Any Surgery Or Previous trauma To The Area? _____

**VISUAL ANALOGUE SCALE for their Primary Complaint:
INDICATE THE INTENSITY OF THEIR PAIN
WITH AN X**

NO PAIN WORST
0 _____ 10

What is their SECONDARY COMPLAINT? Please describe in detail. Note when you first noticed their condition and describe carefully any factors that you suspect may have played a role in its onset and continuation?

**VISUAL ANALOGUE SCALE for their Secondary Complaint:
INDICATE THE INTENSITY OF THEIR PAIN
WITH AN X**

NO PAIN WORST
0 _____ 10

If there is a THIRD OR MORE ISSUES, please list them below in order of severity or importance to you. If they have a specific health condition please describe in detail as in their secondary complaint. Please include the types of practitioners you have seen for this issue, and the results

<u>DO THEY:</u>	<u>YES</u>	<u>NO</u>	<u>HOW MUCH / HOW OFTEN?</u>	<u>PRODUCTS / DOSAGE</u>
SMOKE	_____	_____	_____	
CAFFEINE	_____	_____	_____	
ALCOHOL	_____	_____	_____	TYPE: _____
EXERCISE	_____	_____	_____	
TAKE VITAMINS	_____	_____	PRODUCTS/DOSAGE _____	

Do they have any allergies to any drugs, herbs, foods, animals or other? Y / N What? _____

Patient Name _____
Date _____

PLEASE LIST ANY MEDICATIONS OR OVER THE COUNTER MEDICATIONS THEY ARE CURRENTLY TAKING, FOR WHAT REASON, AND DOSAGE:

OFFICE USE ONLY

Any Surgery Anywhere In The Body? (Provide dates) _____

Are They Taking Immune Strengthening Supplements? _____

Are They Being Treated For Any Other Conditions? _____

Have They Ever Been Involved In An Auto Accident? Y / N If yes, when? _____

FEMALE: Are They Pregnant? Y / N PLEASE INITIAL _____

Date Last Menstrual Cycle began? _____

PERSONAL HABITS:

What do they enjoy most in their life? _____

What are their interests and hobbies? _____

What do they worry about most in their life? _____

On a scale of 1-10, how would you rate their quality of sleep? _____

What do you use for drinking water? (bottled, filtered or tap water) Ounces of water per day _____

OCCUPATIONAL/HOUSEHOLD

How long have you lived at present address? _____ (Please describe location. I.e.: old / new, construction, damp, moldy) _____

Where have you lived previously? _____ (Please describe location. I.e.: old / new, construction, damp, moldy) _____

Do you have specialized air filtration at home? Y / N Do you live in the city? Y / N

FAMILY HEALTH HISTORY:

- | | | | |
|-----------------|------------------------|---------------------|---------------------|
| _____ ALLERGIES | _____ DEPRESSION | _____ HEART DISEASE | _____ SICKLE CELL |
| _____ ANEMIA | _____ DIABETES | _____ SKIN DISEASE | _____ CATARACTS |
| _____ ARTHRITIS | _____ GENETIC PROB. | _____ SEIZURES | _____ VENEREAL DIS. |
| _____ ASTHMA | _____ HYPOGLYCEMIA | _____ STROKE | |
| _____ CANCER | _____ HIGH BLOOD PRES. | _____ THYROID PROB. | |

What is their weakest organ system and why? _____

PERSONAL HEALTH HISTORY: List all current © or past (P) conditions

_____ (C or P)	_____ (C or P)	_____ (C or P)
_____ (C or P)	_____ (C or P)	_____ (C or P)
_____ (C or P)	_____ (C or P)	_____ (C or P)

Patient Name: _____

Parent's Name _____

Parent's Signature _____ Date: _____

Do you have anything else you would like to comment on?

Patient Name _____
Date _____

PAIN DRAWING

Tell Us Where You Hurt

Mark the areas on your body where you feel discomfort. Mark areas of radiating pain from origin to end point. Use the appropriate symbols below to describe the character of the pain.

ACHE >>>>
>>>>

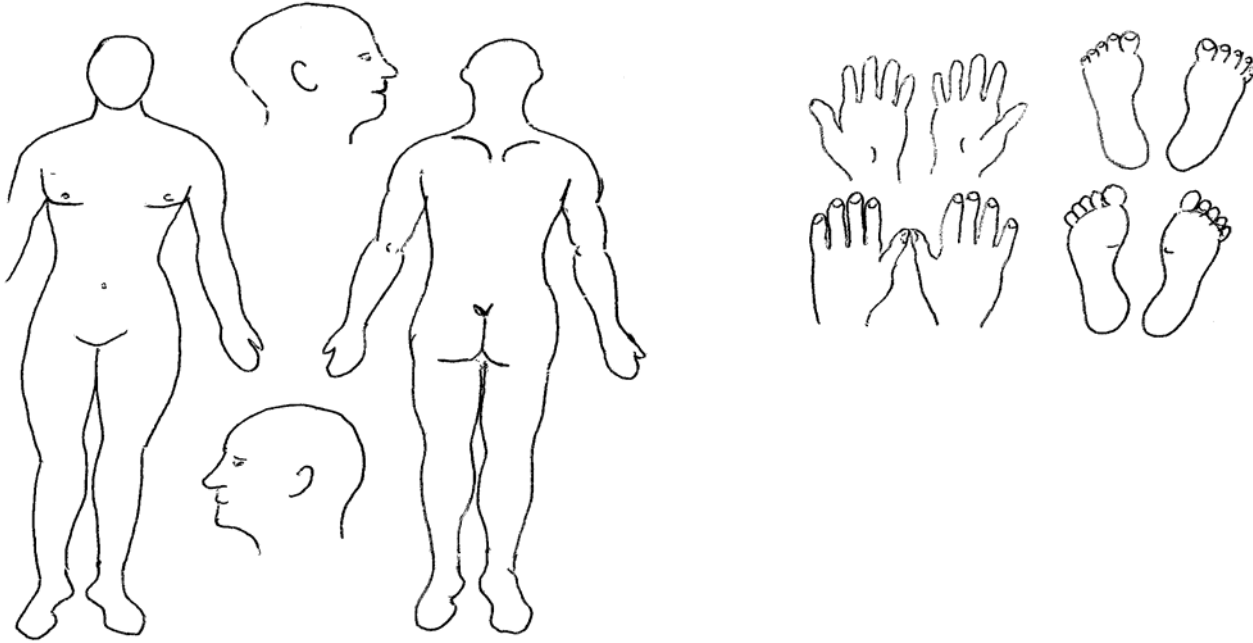
NUMBNESS =====
=====

PINS & NEEDLES *****

BURNING+++++
+++++

STABBING ///////////////
/////////////////

THROBBING ~~~~~~
~~~~~



Different people understand information via different means. Some are more visual, some by listening to audio or verbal, and some by feelings (kinesthetic). So that we may be most effective in communicating information to you in their preferred style, please place a number 1 to 3 next to the appropriate style you learn and understand (1 best - 3 least):

\_\_\_\_\_ Visual (by seeing)    \_\_\_\_\_ Auditory (by hearing)    \_\_\_\_\_ Feelings (Kinesthetic)