

## Health History Form-Children

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Massage Therapy Before? Yes No

Other treatments? Chiropractic Physiotherapy Naturopath

Health Conditions (check all that apply)

\_\_\_ Chronic Cough

\_\_\_ Asthma

\_\_\_ Diabetes

\_\_\_ Bronchitis

\_\_\_ Grind teeth

\_\_\_ Skin Conditions

\_\_\_ Warts

\_\_\_ Allergies

\_\_\_ Epilepsy

\_\_\_ Cancer- Where \_\_\_\_\_

- When \_\_\_\_\_

- Treatment \_\_\_\_\_

\_\_\_ Other medical Conditions: \_\_\_\_\_

Childs Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_ Growing Pains

\_\_\_ Vision Problems

\_\_\_ Hearing Problems

\_\_\_ Sleep Well? Yes No

\_\_\_ Sports? What Sport? \_\_\_\_\_

\_\_\_ Injuries? Where? \_\_\_\_\_

\_\_\_ Surgery? Where/When \_\_\_\_\_

\_\_\_ Medications \_\_\_\_\_

\_\_\_ Muscle pains? Where? \_\_\_\_\_