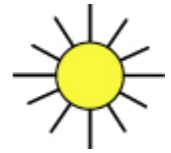


Braile Chiropractic



Child Health Form

To be filled out by parent or guardian Please print clearly and fill in completely

Print Child's Name _____ Date of Birth _____

Street Address _____ Apt.# _____

City _____ State _____ Zip _____ Phone _____

Please Check ✓ Sex: Male Female Right handed Left handed

Health History:

Give reason for seeking chiropractic care: _____

Describe any health problems, including how long child has had them: _____

Is child under the care of any other doctor? Yes No

If Yes, please list the doctors your child is seeing, the conditions being treated for, and any progress.

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays child has had in the past 2 years: _____

Chiropractic History:

Has child been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of any chiropractic x-rays _____ How long was child under care? _____

Are other family members under chiropractic care? - Yes No Who? _____

Please describe any other information you feel would assist us in the care of you child?

Print Parent's Name: _____

Parent's Signature : _____ **Date:** _____

I authorize Braile Chiropractic to initiate examination and care for the minor listed above as I am this child's parent or legal guardian.