



**MURRAY**  
FAMILY CHIROPRACTIC

*Pain Relief to Wellness*

*An unhealthy spine can have far reaching effects on your child's health & development.  
The birthing process itself can be the source of your child's **first subluxation**.  
Proper spinal function promotes optimal development, **naturally!***

**CHILDREN'S HEALTH HISTORY**  
(3-13 years)

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month/Day/Year

Mother's Name \_\_\_\_\_

**YOUR CHILD'S HISTORY:**

1. As a baby / toddler, (**birth to 4 years**), did any of the following occur?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Tumble down stairs            | <input type="checkbox"/> Fall out crib     |
| <input type="checkbox"/> Play in "Jolly Jumper"   | <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Slow weight gain  |
| <input type="checkbox"/> Frequent crying spells   | <input type="checkbox"/> Frequent fevers               | <input type="checkbox"/> Colic             |
| <input type="checkbox"/> Frequent colds           | <input type="checkbox"/> Constipation                  | <input type="checkbox"/> Tonsillitis       |
| <input type="checkbox"/> Frequent ear infections  | <input type="checkbox"/> Frequent bouts of diarrhea    | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Reaction to vaccination  | <input type="checkbox"/> Involved in car accident      | <input type="checkbox"/> Other _____       |

Please explain 'other': \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. As a young child, (**5-13 years**), did any of the following occur?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Fall from a tree              | <input type="checkbox"/> Bed wetting            | <input type="checkbox"/> Stomach pains    |
| <input type="checkbox"/> Fall off a bicycle            | <input type="checkbox"/> Hyperactivity / Autism | <input type="checkbox"/> Scoliosis        |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties  | <input type="checkbox"/> Allergies        |
| <input type="checkbox"/> Sports accident               | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Leg / knee pains |
| <input type="checkbox"/> Involved in car accident      | <input type="checkbox"/> Other: _____           |   |

Please explain 'other': \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. **Vaccinations received?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any reactions? \_\_\_\_\_

4. As a **child or adolescent**, has your child experienced any of the following:
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Foot / ankle / knee pains |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Arm / wrist pains      | <input type="checkbox"/> Tingling in arms / legs   |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Neck / back pains         |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Shoulder pains            |
| <input type="checkbox"/> Hyperactivity   | <input type="checkbox"/> Stomach problems       | <input type="checkbox"/> "Growing Pains"           |
| <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Weight gain/loss       | <input type="checkbox"/> Other _____               |

Please explain the 'other' : \_\_\_\_\_  
 \_\_\_\_\_

5. Which of the problems you have checked off in question #4 is the worst? \_\_\_\_\_

Is this problem:     Constant             Re-occurring bouts

6. How long has it persisted? \_\_\_\_\_

7. When is it at its worst & how does it make your child feel? \_\_\_\_\_  
 \_\_\_\_\_

8. What have you done about it that has NOT worked? \_\_\_\_\_  
 \_\_\_\_\_

9. What makes it worse? \_\_\_\_\_

10. What effect does it have on his/her participation in daily activities? \_\_\_\_\_  
 \_\_\_\_\_

11. Describe any hospital stays: \_\_\_\_\_  
 \_\_\_\_\_

12. Approximately how many times have antibiotics been prescribed and or what conditions? \_\_\_\_\_  
 \_\_\_\_\_

13. List any medications your child is currently taking: \_\_\_\_\_  
 \_\_\_\_\_

14. Is there anything else you feel we should know? \_\_\_\_\_  
 \_\_\_\_\_

**THANK YOU !**

\_\_\_\_\_  
 Signature of Parent or Guardian

\_\_\_\_\_  
 Date