

# GENERAL HEALTH HISTORY

HealthStar Chiropractic Center  
7525 Mitchell Road, Suite 300, Eden Prairie, MN 55344

**Patient Name** \_\_\_\_\_ *Mark the conditions that apply to you.*

<b>Past</b>	<b>Present</b>		<b>Past</b>	<b>Present</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems
<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains
<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems
<input type="checkbox"/>	<input type="checkbox"/>	Medication Side Effects	<input type="checkbox"/>	<input type="checkbox"/>	Temper Tantrums
<input type="checkbox"/>	<input type="checkbox"/>	Recurring Fevers	<input type="checkbox"/>	<input type="checkbox"/>	ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds / Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Ever Needed Stiches
<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

1. List any medications being taking: \_\_\_\_\_

2. Number of courses of Antibiotics child has taken in the last 6 mo. \_\_\_\_\_ Total during lifetime \_\_\_\_\_

3. Name of Pediatrician and Other Doctors: \_\_\_\_\_

4. Date of Last Visit \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason: \_\_\_\_\_

5. Name of Obstetrician / Midwife: \_\_\_\_\_

6. Location of Birth:  Hospital  Birthing Center  Home

7. Complications During Pregnancy:  No  Yes Explain: \_\_\_\_\_

8. Ultrasounds During Pregnancy:  No  Yes How Many: \_\_\_\_\_

9. Medication During Pregnancy / Delivery:  No  Yes List: \_\_\_\_\_

10. Cigarette / Alcohol Use during Pregnancy:  No  Yes

11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor":  No  Yes  
Name: \_\_\_\_\_

## PAST HISTORY

12. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_

13. List any past falls, bumps, bruises: \_\_\_\_\_ Was any care received? \_\_\_\_\_

14. List any past sport, recreational, or home injuries: \_\_\_\_\_

15. Please describe any past conditions and treatment received: \_\_\_\_\_

16. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

**Father's side:**  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

**Mother's side:**  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

**Is there any other family history you want us to know?** \_\_\_\_\_