

5. In your child's whole life, what were his/her 5 most serious physical traumas/stresses (eg. automobile jarring/impacts, school stress, recreational activities, sports, falls)

Trauma	Date of trauma
1)	
2)	
3)	
4)	
5)	

6. Check any of the following conditions your child has suffered from during the past year:
- | | | | | |
|---|--|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Seizures | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Growing or Back Pains | <input type="checkbox"/> Colic | | |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Other _____ | | |

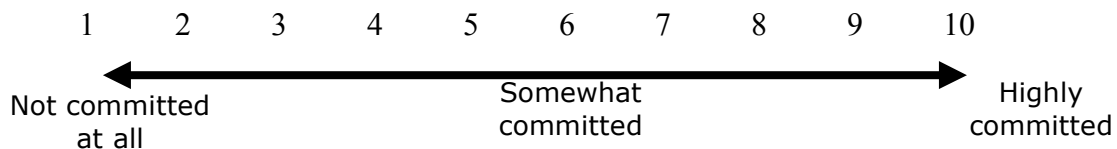
7. How many prescriptions of antibiotics has your child taken in the last year? _____
 Estimate how many in your child's lifetime: _____

8. How many other prescription or over the counter medications has your child taken in the last year? _____

Please name them: _____

9. How many different vaccinations has your child had in their lifetime?

On a scale of 1 to 10 (10 being the highest), rate your commitment if chiropractic care can help correct this problem or prevent future health problems (*circle number*):



I give Dr. Jenkins permission to perform a comprehensive spinal health exam with the intent to determine if my child has any functional or structural spinal problems.

 Parent/Guardian Signature

 Date

