KehoeFamily Chiropractic

It is easier to grow a healthy child, than it is to fix an unhealthy adult.

Welcome to our office. Help us get to know your child.

Child's Name:	**Preferred Name:**
Name of Parents (Guardians):	**Relationship:**
Address: City State Zip	
Child's Date of Birth:	**Parent's Email Address:**
Parent's Phone Number:	**Home or Cell**
How would you like to receive complimentary appointment reminders? TEXT EMAIL CALL None Needed **If text is requested, what company do you use as your cell phone carrier?**	
School your child attends:	**Grade level:**

Lifestyle Habits:

Please circle all that apply & specify amounts:	**Drink Coffee_____**	**Drink Milk _____**	**cow soy nut OTHER**
	Drink Tea _____	**Drinks Juice _____**	**Fast Food _____**
	Drink Soda _____	**Eats Candy _____**	

How much water does your child drink/day?	**What does your child do for exercise? _____** **How Often: Daily _____x Weekly** **They don't exercise regularly**
How would you describe your child's diet? Poor Fair Adequate Good Excellent	
Is your child on a special diet? (Paleo Vegetarian Dairy Free…)	**# Fruits & Vegetables/Day**
Does your child have a cell phone? YES NO How much time do they spend on their phone/day? 0-1 hrs 2-4 hrs 4+hrs	
How much sleep does your child get on most nights? < 8hrs 8-10 hrs 10-12 hrs I don't know	
How much time does your child spend outdoors on most days? < 1hr 2-3 hrs 3+hrs	
Has your child recently been vaccinated? YES NO If yes, for what?	
Has your child ever had an adverse reaction to a vaccine? YES NO NOT SURE **If yes, please explain:**	

Please check the one statement that best describes your child's academic progress:

- ○ **My child does very well academically.**
- ○ **My child struggles with some subjects but overall enjoys learning.**
- ○ **My child has difficulty staying organized and getting their work finished on time.**

Medications (include over the counter)	For what reason	For How Long
Vitamins/Supplements/Herbs	**For what reason**	**For How Long**

Healthcare History

Healthcare practitioners your child has seen in the last year			
Name	**City**	**Last Visit**	**Reason for your visit**

List ALL Surgeries/Hospitalizations/Accidents/Stitches/Broken Bones		
Type	**Date**	**Recovery outcome?**

Below is a list of symptoms. Please check if your child has had or is currently suffering from any of the following:

Past	Symptom	Present
	neck pain	
	headaches	
	shoulder pain	
	breathing troubles	
	menstrual cramps	
	allergies	
	eating disorder	
	discolored urine	
	irritable bowel	
	violent behavior	
	electronic addiction	
	fatigue	
	cancer	
	depression	

Past	Symptom	Present
	low back pain	
	arm/hand tingling	
	leg pain	
	cycle irregularities	
	blurred vision	
	poor appetite	
	fainting	
	depression	
	trouble sleeping	
	leg/foot numbness	
	trouble staying focused	
	ear pain	
	leg cramps	
	substance abuse	

Past	Symptom	Present
	migraines	
	jaw pain/clicking	
	heart problems	
	frequent urination	
	sinus issues	
	excessive appetite	
	uncontrolled anxiety	
	gas/bloating	
	constipation	
	painful urination	
	mid back pain	
	hearing loss	
	hip pain	
	skin troubles	

CURRENT CONDITION

Reason for your child's visit today? Wellness/Maintenance OTHER Specify:

How long has this bothered them? _____ Days _____ Months _____Years

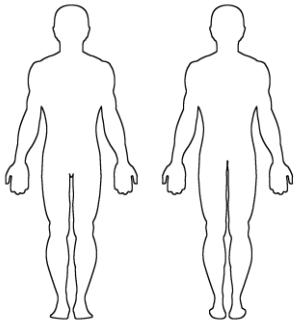
Has your child been under chiropractic care before? YES NO	**How long ago? If yes, was it for this condition? YES NO**
Has your child seen anyone else for this ? YES NO	**Who?**
Was the outcome helpful? YES NO UNSURE	**When was your last visit?**

What else have you done for this?

What makes your child's situation better?	**What make their situation worse?**

On a scale of 0-10 (0=no pain 10= most pain) How does your child rate the pain with this condition?

Please mark the diagram with the location(s) of your child's health concern:
Is there anything else we should know?



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