Kid's History Form

Child's Name Age Date of Birth
Home Address City
State Zip Code Home Phone
Email:
Name of Parents/Guardians
How did you hear about Bliss?
Has your family ever had their spine or nerve system examined? Yes or No With Whom?
Do you have a Family Doctor/Pediatrician? Yes or No Name
What is your motivation for seeking care for your child in this office?

Birth History

Was he/she carried to full term? Yes or No
Was an ultrasound or amniocentesis performed? Yes or No
Was the birth difficult or traumatic? Yes or No
Explain:
Did the baby present as one of the following: Breech Posterior Vertex
During the pregnancy did the mother of this child:
Smoke Drink Alcohol Take medication Do Recreational Drugs
Explain:
The birth and delivery took place at: Home In the hospital At a birthing center
The birth and delivery was a: Caesarian section Natural delivery Water birth Forceps Vacuum extraction
During the birth did the mother:
Have an episiotomy? Yes or No
Receive any medication? Yes or No
Explain:
Have an epidural or any anesthesia? Yes or No
Explain:
Have a fetal monitor on? Yes or No Explain

Physical Trauma

Has the child had any:
Falls Car accidents Sport injuries Broken bones
Please Explain
Is your child involved in any athletic activities or extra-curricular activities? Yes or No
Please List:
Do/did you notice a position in which your child seems uncomfortable? Yes or No
Please Explain:
Does/did your child have tubes in the ears? Yes or No
If yes, at what age where they put in?
Has your child had any other surgery? Yes or No
Please Explain:

Emotional/Mental Trauma

Please circle any of the following emotional/mental stresses that the child has experienced:
Illness Parent's divorce School Abuse Loss of loved one Family
Comments
Does your child express emotion easily? Yes or No
Please Explain:
Does your child have any difficulty sleeping? Yes or No
Please Explain:
Does your child have unusual crying spells? Yes or No
Please Explain:

Chemical Trauma

What is your child's diet like? Please Explain:

Is your child currently taking any medication? Yes or No

Please Explain:

Has your child been vaccinated? Yes or No

If yes, were there any reactions to the vaccinations? Yes or No

Please Explain:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, downstairs, etc.)

Was this the case with your child? Yes or No

Please Explain:

Do you have any concerns about your child's development or health? Yes or No

Please Comment:

Are there particular cartoon characters, figures, or names that create rapport with your child?

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary

Signature of Parent or Guardian Date

Printed Name of Parent or Guardian

We thank you for allowing us the privilege of being an integral part of your child's health and well-being.
We consider this the utmost expression of faith and will give your child the highest degree of care that we can provide.