GENERAL HEALTH HISTORY

Elite Spine Chiropractic
20 Creekview Ct. Ste. Greenville, SC 29615

Patient Name_______________________________________ ***Mark the conditions that apply to you.***

Past	Present	Condition
❑	❑	Headaches
❑	❑	Ear Infections
❑	❑	Colic
❑	❑	Allergies / Asthma
❑	❑	Medication Side Effects
❑	❑	Recurring Fevers
❑	❑	Digestive problems
❑	❑	Bed Wetting
❑	❑	Chronic Colds/Sinus
❑	❑	Vision Problems
❑	❑	Sleeping Problems
❑	❑	Growing Pains
❑	❑	Dental Problems
❑	❑	Temper Tantrums
❑	❑	ADHD
❑	❑	Seizures
❑	❑	Scoliosis
❑	❑	Ever Needed Stitches
❑	❑	Other ____

1. List any medications being taken:____
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____

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16. Please list any past hospitalizations and surgeries: ____

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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?____