

**COMPLETE THIS PAGE FOR CHILDREN 9-13 YEARS OF AGE**

**CHILD'S CURRENT HEALTH**

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?  YES  NO  
PLEASE EXPLAIN:

---

HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT DISLOCATION?  
 YES  NO  
PLEASE EXPLAIN:

---

HAS YOUR CHILD EVER BEEN HOSPITALIZED?  YES  NO  
PLEASE EXPLAIN:

---

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?  YES  NO  
PLEASE EXPLAIN:

---

HAS YOUR CHILD EVER HAD SURGERY?  YES  NO  
PLEASE EXPLAIN:

---

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?  
 YES  NO  
PLEASE EXPLAIN:

---

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?  
 YES  NO  
PLEASE EXPLAIN:

---

DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT?  
 YES  NO  
PLEASE EXPLAIN:

---

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)  
 YES  NO  
PLEASE LIST:

---

PLEASE RATE YOUR CHILD'S STRESS LEVELS ON A SCALE OF 1-10 (10=HIGH)  
SCHOOL: 1 2 3 4 5 6 7 8 9 10  
PERSONAL: 1 2 3 4 5 6 7 8 9 10  
PLEASE EXPLAIN:

---

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

**CHILD'S HEALTH HISTORY**

**INSTRUCTIONS:** Please check each of the conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIFFICULTY/PAINFUL/IRREGULAR PERIODS	<input type="checkbox"/> NECK STIFFNESS/PAIN
<input type="checkbox"/> BACK PAIN/STIFFNESS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SHOULDERS/ELBOW, WRIST PAIN
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> HIPS, KNEES, ANKLES	<input type="checkbox"/> STRESS
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS

**NUTRITION**

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET?  
 YES  NO  
PLEASE EXPLAIN:

---

DOES YOUR CHILD HAVE FOOD ALLERGIES?  
 YES  NO  
PLEASE EXPLAIN:

---

DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURRING SKIN RASHES?  
 YES  NO  
PLEASE EXPLAIN:

---

DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?  
 YES  NO  
PLEASE EXPLAIN:

---

DOES YOUR CHILD ELIMINATE STOOLS EACH DAY?  
 YES  NO  
PLEASE EXPLAIN:

---

WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?

---

WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?

---

WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?

---

WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?

---

HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?