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### ENTRY HISTORY KIDS

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Other Symptoms (circle):    Dizziness    Visual Changes    numbness    tingling    weakness;

Other \_\_\_\_\_

Is your pain: Constant \_\_\_\_, intermittent \_\_\_\_, dull \_\_\_\_, sharp \_\_\_\_, local \_\_\_\_, radiating \_\_\_\_, vague \_\_\_\_

Date pain began: \_\_\_\_\_    Immediate onset \_\_\_\_\_    Gradual onset \_\_\_\_\_

How did it start? \_\_\_\_\_

Have you had pain like this before? \_\_\_\_\_ When? \_\_\_\_\_

Is there a family history of this or similar symptoms? (Please explain) \_\_\_\_\_

Is this condition interfering with your: work \_\_\_\_    sleep \_\_\_\_    daily routine \_\_\_\_    sports/exercise \_\_\_\_

Other \_\_\_\_\_

What other doctors have you seen for this condition? \_\_\_\_\_

If you have seen a chiropractor before did they focus on the neck and back pain? \_\_\_\_\_, or, also on overall health and well being as the underlying cause of your problem? \_\_\_\_\_

Previous surgery and fractures \_\_\_\_\_

Previous auto accidents, injuries to the spine and loss of consciousness \_\_\_\_\_

Please list recent xrays, MRI, and other diagnostic tests \_\_\_\_\_

Allergies (include foods and medications) \_\_\_\_\_

Have you ever had a whole lot of vaccinations at one time? \_\_\_\_\_, When? \_\_\_\_\_

What medications are you currently taking \_\_\_\_\_

Have taken in the past six months \_\_\_\_\_

Name:

Date:

What supplements are you currently taking \_\_\_\_\_

How much time do you spend in front of a computer \_\_\_\_\_ , TV \_\_\_\_\_, Cell Phone use \_\_\_\_\_ .

Do you have trouble getting to sleep at night \_\_\_\_\_ Sleeping through the night \_\_\_\_\_

Wisdom teeth removed \_\_\_\_\_ Gall Bladder removal \_\_\_\_\_ Appendectomy \_\_\_\_\_

Was your birth natural \_\_\_\_\_ Premature \_\_\_\_\_ C-section \_\_\_\_\_ Forceps \_\_\_\_\_ Weight \_\_\_\_\_

Transverse lie \_\_\_\_\_ Any other in uterine constraint \_\_\_\_\_

Length of labor \_\_\_\_\_ Epidural \_\_\_\_\_ Ultraounds \_\_\_\_\_ APGAR \_\_\_\_\_

Breast fed? \_\_\_\_\_ , for how long? \_\_\_\_\_ List your scars \_\_\_\_\_

O you, orDid you have ear infections \_\_\_\_\_ ; how often \_\_\_\_\_

How often do you have a bowel movement \_\_\_\_\_ , Is urination painful or difficult \_\_\_\_\_

How much water/day do you drink \_\_\_\_\_ , Coffee \_\_\_\_\_ , what do you put in it \_\_\_\_\_

How much tea \_\_\_\_\_, what do you put in it \_\_\_\_\_; soda pop \_\_\_\_\_, diet or regular (circle)

What foods do you crave \_\_\_\_\_ Do you have a sweet tooth \_\_\_\_\_

What foods do you eat regularly? \_\_\_\_\_

\_\_\_\_\_ How often do you eat \_\_\_\_\_

Describe your energy level \_\_\_\_\_

Do you exercise? \_\_\_\_\_ , what exercise do you do? \_\_\_\_\_

Are you stressed? \_\_\_\_\_ What stresses you out? \_\_\_\_\_

Please write the goals you hope to reach with treatment: \_\_\_\_\_

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