HEALTH QUEST CHIROPRACTIC
Confidential Medical History

Date_____ Care Card Number _____

Child's Name_____ Birthdate mm/day/yr_____

Parent's/Guardian's name _____ Phone number _____

Address_____ Postal Code_____

Occupation_____ Place of employment_____

Phone# (Home)_____(Work)_____

Email Address:_____

Who referred you to our office? _____

Who is your current Medical doctor: Dr. _____ city: _____

What is your main concern? _____

Any secondary concerns?_____

Vitals-

Height:_____ in / cm Weight: _____lbs/ Kg

Birth: Natural Delivery ( ) Caesarean ( ) Duration of Labor _____-
Forceps ( ) Suction ( )

Medical conditions- please check all that you have or have had:

( ) diabetes	( ) allergies	( ) colic	( ) spits up
( ) asthma	( ) heart conditions	( ) constipation	
( ) skin conditions	( ) epilepsy or seizure	( ) immunized	
( ) back sleeper	( ) side sleeper	( ) difficult to burp	
( ) solids	( ) breast fed	( ) formula	

Frequency of feeding _____ Duration of sleep _____

( ) **Contagious conditions** (eg. Hepatitis or HIV): _____
( ) Other:_____

( ) List any inherited diseases in your family (eg. cancer, diabetes, etc) _____
_____

Medications:
(Doctor/patient confidentiality laws protect this document. For your safety please answer honestly.)

( ) Pease list any other medication being taken and what it was prescribed for:

-_____ - _____

-_____ - _____