GENERAL HEALTH HISTORY

HOYER CHIROPRACTIC
21 South 6th St. Estherville, IA 51334

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

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