



HEALTH HISTORY UPDATE

To assist us in keeping your child's medical history up-to-date, please answer the following:

Child's Name _____ Age _____
 Parent's Name _____ DOB _____
 Yes, there has been a change in address, phone number and/or email
 Home Address _____ Zip _____
 Home Phone # _____ Work Phone # _____ Mobile Phone# _____
 Email Address _____

- Yes No Has your child seen a physician since your last visit?
If so, why? _____
- Yes No Has your child's medical history changed since your last visit?
If so, how? _____
- Yes No Is your child taking any medication at the present time?
What and why? _____
- Yes No Have there been any injuries to the head and neck in the last six months?
If so, what? _____
- Yes No Are there any areas or concerns that you'd like us to pay special
attention to today? _____

- Yes No Has your water supply changed? If so, to what? _____
- Yes No Do you feel that you and your child are treated well in our office?
If not, why? _____
What do you like best about your treatment in our office? _____

What would you suggest to improve our service in the future? _____

Please indicate how you would prefer to receive appointment reminders from us (check all that apply):

- email text message phone call

Signed _____ Date _____