Sozo Chiropractic & Wellness, LLC
409 W. Wall St.
Grapevine, TX 76051
469-223-8836
www.sozochiro.com

Youth History Form

Please complete the following as completely as possible for all children you wish to receive chiropractic care.

Date: _____ Parent's Names _____

Child's Name(s):

_____ M / F DOB: _____ Age: _____

_____ M / F DOB: _____ Age: _____

_____ M / F DOB: _____ Age: _____

_____ M / F DOB: _____ Age: _____

_____ M / F DOB: _____ Age: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Has your child/ren every received chiropractic care? Yes No

If yes, previous DC's name and reason for visit: _____

_____

Name of Medical Doctor/Pediatrician: _____

Date of last MD visit and reason: _____

Present health complaints/concerns, Major & Minor:

_____

_____

When did it begin? _____

Did it come on gradually or suddenly? _____

Has this problem affected the child's: Sleep Eating School Daily Routine

Is there pain associated with your chief complaint(s)? Yes No

Does the pain radiate? To where? _____

Is the problem getting: Better Worse Not Changing

The pain: Is Constant Comes and Goes

Have you seen anyone else for this issue? Yes No

If yes, who? When? Outcome?_____

Has anything/anyone helped? Yes No

If yes, who or what? _____

Has the child ever been treated for a similar problem? If yes, please describe. Yes No

_____

Any traumas resulting in bruises, cuts, stitches, or fractures? No Yes - Explain

_____

Any hospitalizations or surgeries? No Yes - Explain

_____

Any athletics including sports, dance, gymnastics, etc? No Yes - Explain

_____

Any: Night Terrors Sleep Walking Difficulty Sleeping Bed Wetting

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AUTHORIZATION FOR CARE OF A MINOR (UNDER 18 YEARS)

Parents' Names: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____

Parent/Guardian Print Name: _____

Date: _____
