# 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_____

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