

**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

-----  
**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: \_\_\_\_\_

-----  
**FOR CHIROPRACTOR'S USE ONLY**

Palpatory Findings:

Tone of Musculature:

Leg Check Analysis:

Listings:

Vertebrae Adjusted:

Additional Information: