

CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

REASON FOR THIS VISIT

Name _____
Home Phone _____ Birthdate _____
Age _____ Gender M F
Height _____ Weight _____
Address _____
City/State/Zip _____
Parent's Name _____
Parent's Employer _____
Parent's Work Phone _____
Payment Method Cash Check Credit Card
Crdt Cd. # _____ exp _____
Health Insurance Co. Name _____
Policy Number _____
Policy Holder's Name _____
Policy Holder's Social Security # _____

Describe the purpose of this visit. _____

Is the purpose of this appointment related to

- sports auto fall home injury
 chronic discomfort other

Explain _____

When did this condition begin? _____

Has this condition

- gotten worse stayed constant comes and goes

Does this condition interfere with

- sleep daily routine other activities

Explain _____

Has this condition occurred before? Yes No

Explain _____

Have you seen other doctors for this condition? Yes No

Dr.'s Name(s) _____

Type of Treatment _____

Results _____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:

.....take any medication? No Yes

Explain _____

.....smoke or consume alcohol? No Yes

.....experience any illness? No Yes

Explain _____

Approximately how long did labor last? _____ hours

Was labor chemically induced? No Yes

Was labor doctor assisted? No Yes

Was a C-Section performed? No Yes

Were forceps or vacuum extraction used? No Yes

Did the delivery doctor pull or twist the baby during delivery? No Yes

Was the delivery premature? No Yes

If "Yes", at _____ month and _____ weight

Check any of the following if the child experienced it immediately after birth.

- Jaundice Respiratory Problems
 Feeding Problems Displaced or Broken Joints
 Other Condition(s)

Explain _____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis

- | | |
|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Pink Eye |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Sleeping Disorders | <input type="checkbox"/> Tubes in the Ears |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hyperactivity | _____ |
| <input type="checkbox"/> Constipation | _____ |
| <input type="checkbox"/> Bed Wetting | _____ |

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? No Yes

Has your child:
.....been hospitalized? No Yes

.....had a severe fall? No Yes

.....been in a car accident? No Yes

Has your child ever taken antibiotics? No Yes

If "Yes", explain _____

Is your child currently taking any medication? No Yes

If "Yes, explain _____

Does your child have difficulty interacting with schoolmates or friends? No Yes

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? No Yes

What changes (if any) in your child's health or behavior would you like accomplished? _____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care** — Symptomatic relief of pain or discomfort
- Corrective Care** — Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care** — Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my child.

Parent/Guardian's Signature _____

Date _____

VACCINATIONS

Have you chosen to vaccinate your child? No Yes

DPT MMR Polio Chicken Pox

If "Yes", check all vaccinations the child has received.

Hepatitis Other _____

Describe any and all reactions to vaccine(s). _____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors in this Chiropractic office, and whomever they may designate as their assistants to administer Chiropractic care, to work with my child (name) _____ through the use of adjustments and procedures to the spine, as the Doctor deems appropriate.

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

Patient's Name (Print)

Parent or Legal Guardian's Name (Print)

Parent/Guardian's Signature Authorizing Care

Date (M/D/Y)

Witness' Signature

Who should receive bills for payment on this account?

Parent

Personal Health Insurance

Auto Insurance

Medicare

Medicaid

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							