

CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name _____
Birthdate _____ Age _____
Gender M F Height _____ Weight _____
Address _____
City/State/Zip _____
Home Phone _____
Parent's Name _____

MOTHER'S PREGANCY & 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 Feeding Problems

Respiratory Problems Displaced or Broken joints

Other Conditions

Explain _____

REASON FOR THIS VISIT

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 the condition occurred before?

- Yes No

Have you seen other doctors for this condition

- Yes No

Dr.'s Name _____

Type of Treatment _____

Results _____

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

CHILDREN'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 medications?

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. 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.
- Wellness**- Make sure my child functions at his/her optimum potential.
- I want the doctor to select the type of care appropriate for my child.

VACCINATIONS

Have you chosen to vaccinate your child? No Yes If "yes", check all vaccinations the child has received.

DPT MMR Polio Chicken Pox Hepatitis Other _____

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

INSURANCE INFORMATION

Do you have health insurance? No Yes If "yes", Name of Company _____

Member # _____

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.

Patient's Name (print)

Parent or Legal Guardian Name (print)

Parent/Guardian's Signature Authorizing Care

Date(m/d/y)