

CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

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# _____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:
take any medication? N Y
 Explain _____
smoke or consume alcohol? N Y
experience any illness? N Y
 Explain _____
 Approximately how long did labor last? _____ hours
 Was labor chemically induced? N Y
 Was labor doctor assisted? N Y
 Was a C-section performed? N Y
 Were forceps or vacuum extraction used? N Y
 Did the delivery doctor pull or twist the baby
 during delivery? N Y
 Was the delivery premature? N Y
 If "Yes", at _____ month and _____ weight
 Check any of the following if the child experienced it immedi-
 ately after birth.
 Jaundice Respiratory Problems
 Feeding Problems Displaced or Broken Joints
 Other Condition (s)
 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 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 _____

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 af-
 fect the overall diagnosis.
 Vision Problems Pink Eye
 Headaches Ear Problems
 Sleeping Disorders Tubes in the ears
 Irritability Attention Problems
 Skin Problems Frequent Colds
 Allergies Colic
 Breathing Problems Digestive Problems
 Asthma Other _____
 Hyperactivity _____
 Constipation _____
 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 If "Yes", check all vaccinations the child has received.
 DPT MMR Polio Chicken Pox 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 and 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