WELL BEINGS
Chiropractic Family Health

Children's Health Record

Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Weight: _____ Height: _____ Gender: M◯ / F◯

Parent's Name: _____

Parent's Employer: _____

Parent's Email: _____ Parent's Work Phone: _____

Reason for this Visit

Describe the purpose of this visit: _____
_____
_____

Is the purpose of this visit related to (mark): ☐Sports / ☐Auto / ☐Fall / ☐Home Injury /☐Chronic Discomfort/☐Other
Please Explain: _____
_____
_____

When did this condition begin: _____
_____

Has this condition (Mark): Gotten Worse◯/ Stayed Constant◯/ Comes and Goes◯

Does this condition interfere with (Mark): ☐Sleep / ☐Daily Routine / ☐Other Activities
Please Explain: _____
_____

Has this condition occurred before: Yes◯ / No◯
Please Explain: _____
_____

Have you seen other doctors for this condition: Yes◯ / No◯
Dr.'s Name:_____
Type of Treatment: _____
Results: _____

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Mother's Pregnancy & Labor

During the pregnancy, did the mother:

Take any medication: Yes ◯ / No ◯

Please Explain: _____

_____

Smoke or consume alcohol: Yes ◯ / No ◯

Experience any illness: Yes ◯ / No ◯

Please Explain: _____

_____

Approximately how long did labor last? _____ Hours

Was labor chemically induced? Yes ◯ / No ◯

Was labor doctor assisted? Yes ◯ / No ◯

Was a C-Section performed? Yes ◯ / No ◯

Were forceps or vacuum extraction used? Yes ◯ / No ◯

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

Was the delivery premature? Yes ◯ / No ◯

If yes, at _____ month and _____ weight

Mark any of the following if the child experienced it immediately after birth:

☐Jaundice / ☐Respiratory Problems / ☐Feeding problems / ☐Displaced or Broken Joints / ☐Other

Please Explain: _____

_____

Child's Health History

Please mark 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 and course of care for your child.

☐Vision Problems	☐Pink Eye	☐Headaches
☐Ear Problems	☐Sleeping Disorders	☐Tubes in Ears
☐Irritability	☐Attention Problems	☐Skin Problems
☐Frequent Colds	☐Allergies	☐Colic
☐Breathing Problems	☐Digestive Problems	☐Asthma
☐Hyperactivity	☐Constipation	☐Bed Wetting

Other _____

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Child's Current Health Status

Is your child accident prone? Yes___/ No__

Has your Child:

Been hospitalized? Yes__/ No__

Had a severe fall? Yes__/ No__

Been in a car accident? Yes__/ No__

Has your child ever taken antibiotics? Yes__/ No__

If yes, please explain _____

_____

Is your child <u>currently</u> taking any medication? Yes__/ No__

If yes, please explain _____

_____

Does your child have difficulty interacting with schoolmates or friends? Yes__/ No__

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? Yes__/ No__

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 the 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 care program. Please circle 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.
Dr.'s Choice of 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? Yes___ / No___

If yes, mark all vaccinations your child has received:

☐DPT ☐MMR ☐Polio ☐Chicken Pox ☐Hepatitis

Other: _____

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Authorization to Care for a Minor Child

I hereby authorize the doctors in this chiropractic office, and whomever they may designate as their assistant 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 payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any preexisting 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 the 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 the 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 / Legal Guardian's Name (print): _____

Parent / Guardian's Signature Authorizing Care: _____ Date: _____

Witness' Signature: _____