

# 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 \_\_\_\_\_

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?  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 \_\_\_\_\_

## 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 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 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 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