POWER
CHIROPRACTIC CLINIC

Children's Health Record

Date:

Patient Information:

Name:_____ DOB: _____

Age: _____ Gender: ____ Weight: _____ SSN#: _____

Parent/Guardian's Name: _____

Home phone: _____ Cell Phone: _____

Address: _____

City/State/Zip: _____

Parent's Employer: _____ Phone: _____

Insurance Information:

Health Insurance Company Name: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Prenatal History:

Is your child adopted? ☐ Yes ☐ No

Did mother have any pregnancy complications? _____

Did mother smoke? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

Did mother take Medication? ☐ Yes ☐ No What/Why:_____

Birth History:

How long did labor last? _____ hours

Was labor chemically induced? ☐ Yes ☐ No Doctor assisted? ☐ Yes ☐ No

Was a C-Section Performed? ☐ Yes ☐ No

Were forceps or vacuum extraction used? ☐ Yes ☐ No

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

Was the delivery premature? ☐ Yes Weight and age? _____ ☐ No

Did your child experience any of the following immediately after birth?

☐ Jaundice ☐ Respiratory Problems ☐ Feeding Problems

☐ Displaced or Broken Joints ☐ Other: _____

Child's Health History

Please check any of the following conditions the child has had or currently has:

☐ Vision Problems ☐ Headaches ☐ Sleeping Disorders ☐ Irritability
☐ Skin Problems ☐ Allergies ☐ Asthma ☐ Pink Eye ☐ Colic

☐ Breathing Problems ☐ Hyperactivity ☐ Constipation ☐ Bed Wetting

☐ Ear Problem ☐ Attention Problems ☐ Frequent Colds ☐ Digestive Problems

☐ Other _____

Vaccination History

Have you chosen to vaccinate your child? ☐ Yes ☐ No

If yes, check all that your child has received

☐ DPT ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis ☐ Vitamin K

☐ Other _____

Describe any and all reactions to vaccine(s)

_____

Child's Current Health Status:

Check all that apply to your child:

☐ Accident prone ☐ Hospitalized ☐ Had a severe fall ☐ Been in a car accident

☐ Difficulty interacting ☐ Nervousness, twitching, or rocking behavior

☐ Taken antibiotics – explain: _____

☐ Currently on medication – explain: _____

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

Reason for Visit

Describe the purpose of this visit: _____

_____

Is this appointment related to any of the following?

☐Sports ☐Auto ☐Fall ☐Injury ☐Chronic discomfort

Explain:_____

When did this condition begin? _____ Has it gotten better? _____

Has this condition interfered with:

☐Sleep ☐Daily routine ☐Other activities

Explain: _____

Has this condition occurred before? ☐Yes ☐No

If yes, when? _____

Has your child seen other doctors for this condition? ☐Yes ☐No

Dr.'s Name(s) _____

Type of treatment _____

Results_____

Goals for Treatment

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. Dr. Hickel 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 Dr. Hickel to select the type of care appropriate for my child.

Parent/Guardian's Signature Date