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? ❑ 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

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

_____

_____

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