

PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____

Birth date _____

SS# _____

Age _____ Gender _____ Weight _____

ABOUT THE PARENT

Name _____

Employer _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

E-mail address _____

Payment method Cash Check Credit card

VACCINATIONS

Have you chosen to vaccinate your child? Yes No

If yes, check all that your child has received.

DPT MMR Chicken Pox Hepatitis Other

Describe any and all reactions to vaccine(s).

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to

Sports Auto Fall Home Injury
 Other

Please 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

Please explain _____

Has this condition occurred before? Yes No

Please explain _____

Have you seen other doctors for this condition?

Yes No

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that _____ Yes No
Doctors of Chiropractic work _____
with the nervous system?

The nervous system controls _____
all bodily functions and systems?

Chiropractic is the largest _____
natural healing profession in the world?

If Chiropractic care starts at birth, you can _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? Yes No

Has any child in your family seen a Chiropractor? Yes No

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

Drugs / Medicine Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy? _____

How was your delivery?

Labor chemically induced Labor was Dr. assisted
 C-section delivery Forceps/Vacuum extraction?
 Did Dr. pull or twist baby? Premature delivery

Please explain _____

Did you nurse the baby? Yes No

Did your baby have colic? Yes No?

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, care plan and the possibility of being accepted for care.

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Sleeping disorders_ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Tubes in the ears |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Other |

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:			
...taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child			
...accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Surgery? Please Explain...			_____
...currently taking any medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...having difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?			_____

GOALS FOR MY CHILDS CARE

People 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 treatment 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 condition.

Parent or guardians signature: _____ Date: _____

Childs name: _____

AUTHORIZATION FOR CARE OF A MINOR

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 condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me 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 Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian: _____ Date: _____