CHILD'S HEALTH RECORD

ABOUT THE CHILD

Name_____

Address_____

City_____ State_____

Zip _____Home phone _____

Birth date _____ Age _____ Gender _____

Referred here by _____

Parents name_____

Parents employer_____

Parents work phone_____

Payment method ☐ Cash ☐ Check ☐ Credit card

Crdt Cd #_____exp date_____

Health Insurance Co Name_____

Policy Number_____

Policy Holder's Name_____

Policy Holder's Social Security #_____

Has he/she been checked by a chiropractor? ❑ Yes ❑ No

MOTHER'S PREGNANCY AND LABOR

During pregnancy, did the mother:

...take medication? ❑ No ❑ Yes
If "Yes" Explain_____

...smoke or consume alcohol? ❑ No ❑ Yes

...experience any illness? ❑ No ❑ Yes
If "Yes" Explain_____

About 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 doctor pull or twist the baby during delivery? ❑ No ❑ Yes

Was the delivery premature? ❑ No ❑ Yes
If "Yes", _____weeks premature and _____weight.

Check any of the following that the child experienced immediately after birth.

❑ Jaundice ❑ Respiratory problems
❑ Feeding problems ❑ Displaced or broken joints
❑ Other Condition(s)
Explain_____

CURRENT HEALTH STATUS

Describe the purpose of this visit _____

_____

When did this condition begin?_____

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, friends or siblings? ❑ No ❑ Yes
Please explain _____

Have you or anyone else noticed that you 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?_____

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 ❑ Influenza ❑ Other_____

Describe any and all vaccine reactions._____
_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has experienced in the past. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis.

❑ Vision problems
❑ Headaches
❑ Sleeping disorders
❑ Irritabliity
❑ 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_____
_____
_____
_____

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 symptom
- ☐ **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.**

AUTHORIZATION TO CARE FOR A MINOR

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 Doctors deem 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 and 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 Signature Authorizing Care Date (M/D/Y) Witness' Signature

FOR OFFICE USE ONLY

Patient Case History

INITIAL	UPDATE 1	UPDATE 2
PRIMARY		
SECONDARY		
TERTIARY		

X-RAY FINDINGS

DATE:_____

VIEWS:_____

IMPRESSIONS: _____

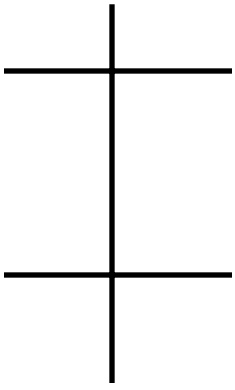
_____

1._____

2._____

3._____

4._____



Level	Left	Right
OC		
AT-1		
AX-2		
C3		
C4		
C5		
C6		
C7		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2		
L3		
L4		
L5		
SAC		