

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 address _____
Work phone _____ Cell _____
Type of work _____
E-mail address _____
Social Security # _____
Insurance Co: _____
Insured's Name: _____
Insured's SS#: _____ DOB: _____

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?	<input type="checkbox"/>	<input type="checkbox"/>
• The nervous system controls all bodily functions and systems?	<input type="checkbox"/>	<input type="checkbox"/>
• Chiropractic is the largest natural healing profession in the world?	<input type="checkbox"/>	<input type="checkbox"/>
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	<input type="checkbox"/>	<input type="checkbox"/>

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?

Feeding problems? Yes No

Vaccinations? 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.

Allergies

Asthma

Attention problems

Bed wetting

Breathing problems

Colic

Constipation

Digestive problems

Ear problems

Frequent colds

Headaches

Hyperactivity

Irritability

Skin problems

Sleeping disorders

Tubes in the ears

Vision problems

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?			

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

AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

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: _____