CHILDREN'S HEALTH RECORDS

ABOUT THE CHILD

Name:_____
Birthdate: _____ Age: _____
Gender: □ M □ F Height: _____ Weight: _____
Address: _____
City/State/Zip: _____
Parent Cell phone: _____
Parent email : _____
Parents' Name (s): _____
_____

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 ○ Feeding Problems ○ Respiratory Problems

○ Displaced or Broken joints ○ Other Conditions
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 condition occurred before?

○ Yes ○ No
Have you seen other doctors for this condition?

○ Yes ○ No
Dr.'s Name: _____
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 this appointment, they can affect the overall diagnosis

○ Vision Problems ○ Constipation ○ Bed Wetting

○ Headaches ○ Sleeping disorders ○ Pink eye

○ Irritability ○ Ear Problems ○ Skin problems

○ Tubes in ears ○ Allergies ○ Attention problems

○ Breathing problems ○ Colic ○ Asthma

○ Hyperactivity ○ Digestive Problems

○ Other_____

CHILDREN'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 <u>currently</u> 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. 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 mal functioning in the body to the highest state of health possible with chiropractic care.
- ○ **Wellness**—Make sure my child functions at his/her optimum potential
- ○ I want the doctor to select the type of care appropriate for my child.

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 charges 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.

_____
Patient's Name (Print)

_____
Parent or Legal Guardian Name (Print)

_____
Parent/Guardian Signature Authorizing Care

_____
Date (Month/day/year)