CHILD HEALTH HISTORY

About the Child

Date_____

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**

Health Insurance Co. Name_____

Policy Holder's Name_____

Policy Holder's Social Security #_____

Who should receive bills for payment on this account?
☐ Parent ☐ Personal Health Insurance ☐ Auto Insurance
☐ Medicare ☐ Medicaid

Reason For This Visit

Describe the Purpose of this visit_____

_____

Is the purpose of this appointment related to:
☐ Sports ☐ Auto ☐ Fall ☐ Home Inury
☐ Chronic Discomfort ☐ Other

Explain_____

When did this condition begin?_____

Has this condition:
☐ Worsened ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:
☐ Sleep ☐ Daily Routine ☐ Other Activites

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_____

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_____

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
☐ Bed Wetting
☐ Pink Eye
☐ Ear Problems
☐ Tubes in the Ears
☐ Attention Problems
☐ Frequent Colds
☐ Colic
☐ Digestive Problems
☐ Hyperactivity
☐ Constipation
☐ Other

Explain_____

Child's Current Health Status

Name_____ Date_____

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? ☐ No ☐ Yes

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. You Doctor will weigh your needs and desires when recommending you 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 they 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 Witness' Signature