

CHIROPRACTIC SOLUTIONS CHILD'S HEALTH RECORD

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Please fill out this form as completely and accurately as possible.

Today's Date _____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____
Gender M F Height _____ Weight _____
Parent's Name _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Business Phone (____) _____
Parent's Employer _____
Parent's Email Address _____

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 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? Yes No Explain: _____

...smoke or consume alcohol? Yes No

...experience any illness? Yes No Explain: _____

Approximately, how long did labor last? _____ hours

Was labor chemically induced? Yes No

Was labor doctor assisted? Yes No

Was a C-section performed? Yes No

Were forceps or vacuum extraction used? Yes No

Did the delivery doctor pull or twist the baby during delivery? Yes No

Was the delivery premature? Yes No

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 and course of care for your child.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping Disorders | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Pink Eye |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Tubes in the Ears | <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Other _____ | |

CHILD'S CURRENT HEALTH STATUS

- Is your child accident prone? Yes No
- Has your child:
- ...been hospitalized? Yes No
 - ...had a severe fall? Yes No
 - ...been in a car accident? Yes No
- Has your child ever taken antibiotics? Yes No If "Yes," explain _____
- Is your child currently taking any medication? Yes No If "Yes," explain _____
- Does your child have difficulty interacting with schoolmates or friends? Yes No
- Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?
 Yes No
- 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. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired to 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 child

Parent/Guardian's Signature

Date

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 (M/D/Y)

Witness Signature