CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name_____

Street_____

City _____State _____Zip_____

Home Tel:_____

Parent's Work Tel:_____

Parent's Cell: _____

Parent's E-mail Address_____

Male___ Female____ DOB_____

Current Height_____ Weight _____

Parent's Name _____

Parent's Employer _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to

☐ wellness / no symptoms ☐ 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 _____

Type of treatment _____

Results _____

MOTHER & BABY 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 _____

Labor and Delivery

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 of Broken Joints

☐ Other Condition(s)

Explain _____

Weight at Birth_____

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.

☐ Vision Problems
☐ Headaches
☐ Sleeping Disorders
☐ Irritability
☐ 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_____
_____
_____

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 you child ever taken antibiotics? ☐ Yes ☐ No

If "Yes", explain _____

Is your child <u>currently</u> taking any medication?

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 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 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? ☐ Yes ☐ No If "Yes", check all vaccinations the child has received

☐ DPT ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis ☐ Other_____

Describe any and all reactions to vaccine(s). _____

_____