

# Child Health Record Form

## ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	
AGE:	
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

## ABOUT THE PARENT

PARENT NAME:	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH:	

## VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HOW DID YOU HEAR ABOUT OUR OFFICE (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY OTHER CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

**PRENATAL HISTORY**

DURING PREGNANCY DID YOU USE:  
 DRUGS/MEDICATIONS       TOBACCO/ALCOHOL  
 IF YES, PLEASE EXPLAIN:

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LOCATION OF BIRTH:  
 HOME       BIRTHING CENTER       HOSPITAL

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DESCRIBE YOUR DELIVERY:  
 LABOR WAS CHEMICALLY INDUCED       LABOR WAS DOCTOR ASSISTED  
 C-SECTION DELIVERY       FORCEPS/VACUUM EXTRACTION  
 DOCTOR PULLED OR TWISTED BABY       PREMATURE DELIVERY  
 PLEASE EXPLAIN:

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HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?  
 \_\_\_\_\_

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?  
 \_\_\_\_\_

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DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

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DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?  
 YES       NO  
 PLEASE EXPLAIN:

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PLEASE DESCRIBE ANY GENETIC DISORDERS AND/OR DISABILITIES:

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BIRTH WEIGHT:  
  
 BIRTH LENGTH:  
  
 APGAR SCORES:    AT 1 MIN \_\_\_\_\_/10      AT 5 MIN \_\_\_\_\_/10

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ULTRASOUND DURING PREGNANCY?     YES       NO      NUMBER: \_\_\_\_\_

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DID YOU BREASTFEED YOUR BABY?       YES       NO  
 IF YES, HOW LONG?

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DID YOU FORMULA FEED YOUR BABY?       YES       NO  
 IF YES, HOW LONG?

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AT WHAT AGE DID YOU INTRODUCE:  
  
 SOLIDS:  
  
 COW'S MILK:

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ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCES?  
 YES       NO

**CHILD'S CURRENT HEALTH**

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?       YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER BEEN HOSPITALIZED?       YES       NO  
 PLEASE EXPLAIN:

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THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).  
 WAS THIS THE CASE FOR YOUR CHILD?       YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?     YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER HAD SURGERY?       YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?  
 YES       NO  
 PLEASE EXPLAIN:

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HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT?  
 YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)  
 YES       NO  
 PLEASE LIST:

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WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

**COMPLETE THE HEALTH HISTORY APPLICABLE TO YOUR CHILDS AGE**

**AGES 0-3 HEALTH HISTORY**

**INSTRUCTIONS:** Please check each of the diseases or conditions that the child 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.

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FREQUENT COLDS, COUGHS,
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> DIFFICULT WEIGHT GAIN	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> COLIC	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SLEEPING DIFFICULTIES

**AGES 4-8 HEALTH HISTORY**

**INSTRUCTIONS:** Please check each of the diseases or conditions that the child 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

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> NERVOUSNESS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> PAIN
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> UPSET STOMACH
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> LEARNING DISORDERS	<input type="checkbox"/> URINARY INFECTIONS

**AGES 9-13 HEALTH HISTORY**

**INSTRUCTIONS:** Please check each of the conditions that the child 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.

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIFFICULTY/PAINFUL/IRREGULAR PERIODS	<input type="checkbox"/> NECK STIFFNESS/PAIN
<input type="checkbox"/> BACK PAIN/STIFFNESS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SHOULDERS/ELBOW, WRIST PAIN
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> HIPS, KNEES, ANKLES	<input type="checkbox"/> STRESS
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS

**NUTRITION**

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE FOOD ALLERGIES?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURRING SKIN RASHES?  
 YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?  
 YES       NO  
 WHICH SUPPLEMENTS & BRAND?

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DOES YOUR CHILD ELIMINATE STOOLS EACH DAY?  
 YES       NO  
 PLEASE EXPLAIN:

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WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?

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WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?

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WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?

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WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?

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HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?

**AUTHORIZATION FOR CARE OF A MINOR**

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 doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care in order to work with my body through the use of adjustments and procedures 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 if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**TERMS OF ACCEPTANCE**

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve function through the adjustment of spinal subluxation(s).
- C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to the spine.
- D. This is a safe, effective procedure applied over one-million times each day in the United States by doctors of chiropractic. Like all forms of health care, while offering considerable benefit, chiropractic may also provide some level of risk. This level of risk is minimal, yet injury can occur in rare cases.
- E. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- F. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- G. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- H. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, \_\_\_\_\_, have read and fully understand the above statements. I understand there may be risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**NOTICE OF PRIVACY POLICY**

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

*I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *Conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: