

# CHILD'S HEALTH RECORD

## ABOUT YOUR CHILD

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home phone \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Social Security # \_\_\_\_\_

Payment method  Cash  Check  Credit card

**IF INSURANCE WILL BE USED TO ASSIST YOU, PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD.**

## REASON FOR THIS VISIT

Describe the purpose of this visit \_\_\_\_\_

Is the purpose of this appointment related to:

Sports  Auto  Fall  Home Injury  Other

Please 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

Has this condition occurred before?  Yes  No

Please explain \_\_\_\_\_

Have you seen other doctors for this condition?  Yes  No

Doctor's Name (s) \_\_\_\_\_

Type of treatment \_\_\_\_\_

Results \_\_\_\_\_

## ABOUT THE PARENT

Name \_\_\_\_\_

Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Social Security # \_\_\_\_\_

## IMMUNIZATION INFORMATION

Have you chosen to vaccinate your child?  Yes  No

If yes, circle all that your child has received. DPT MMR Chicken Pox Hepatitis Other \_\_\_\_\_

Describe any and all reactions to vaccine(s). \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Who may we thank for referring? \_\_\_\_\_

Have you seen or heard about us in/on:  Paper  Sign  YP

Have you been adjusted by a Chiropractor before?  Yes  No

Reason for those visits? \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Approximate date of last visit: \_\_\_\_\_

Has anyone in your family seen a Chiropractor?  Yes  No

## CHIROPRACTIC AWARENESS

Were you aware:

Doctors of Chiropractic work with the nervous system?

Yes  No

The nervous system controls all bodily functions and systems?

Yes  No

Chiropractic is the largest natural healing profession in the

world?  Yes  No

If Chiropractic care starts at birth, you can achieve a higher level

of health throughout life?  Yes  No

## 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 evaluation, care plan and the possibility of being accepted for care.

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Bed Wetting   | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Colic           | <input type="checkbox"/> Constipation  | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Ear Problems  | <input type="checkbox"/> Frequent Colds     |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Sleep Disorders    |
| <input type="checkbox"/> Ear Problems    | <input type="checkbox"/> Tubes in ears | <input type="checkbox"/> Vision Problems    | <input type="checkbox"/> Heart defect  |   |
| <input type="checkbox"/> Surgeries _____ |  |   |  |   |

	No	Yes	If Yes, please explain
Has your child ever:			
...taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...taken any medication (s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____

## AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.

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 doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Chiropractic First directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

### AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my child's condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to my child 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 Dr. 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. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Case History

Chief Concerns: \_\_\_\_\_

History of Condition: \_\_\_\_\_

Birth and Delivery: \_\_\_\_\_

Childhood Injuries / Falls / Accidents: \_\_\_\_\_

Temperament / Attitude: \_\_\_\_\_

Sleep: \_\_\_\_\_ Nutrition: \_\_\_\_\_ Medications: \_\_\_\_\_

What has been done to help this condition (s): \_\_\_\_\_

Other: \_\_\_\_\_