Discover Chiropractic

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Children's Health Record

ABOUT THE CHILD

NAME ______________________________
Phone (H) __________ Birthdate ____________
Age __________ Gender F / M
Height ____________ Weight ____________
Address ______________________________
City/State/Zip ______________________________
Parent's Name ______________________________
Parent's Employer ______________________________
Parent's Phone (W)____________ (C)__________
Payment Method __Cash __Check ___Credit Card
Card # ________________________Exp ________
Health Ins Co. Name ______________________________
Policy # ______________________________
Policy Holder's Name ______________________________
Policy Holder's Social Security Number
____

MOTHER'S PREGNANCY & LABOR

During pregnancy did 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 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/broken joints
___ other condition(s)
Explain ______________________________

REASON FOR THE VISIT

Describe the purpose of the visit: ____________________
____

Is the purpose of the visit 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 ______________________________
Have you seen other doctors for this __Yes __ No
Dr's Name ______________________________
Type of treatment______________________________
Results ______________________________

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
__Constipation
__ Pink Eye
__ Ear Problems
__ Tubes in Ears
__ Attention Problems
__ Frequent Colds
__ Colic
__ Digestive Problems
__ Hyperactivity
__ Bed Wetting

Other Concerns ______________________________
____
____
____
____

CHILD'S CURRENT HEALTH STATUS

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 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? ____________________________

____

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 by 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? __ No ___ Yes If Yes, check all vaccines the child has received.

___ DPT ___ MMR ___ Polio ___ Chicken Pox ___ Hepatitis ___ Smallpox ___AIDS ___Anthrax

Describe any and all reactions to vaccine(s):____

____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors of DISCOVER CHIRORPACTIC, 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 the 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 the 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)

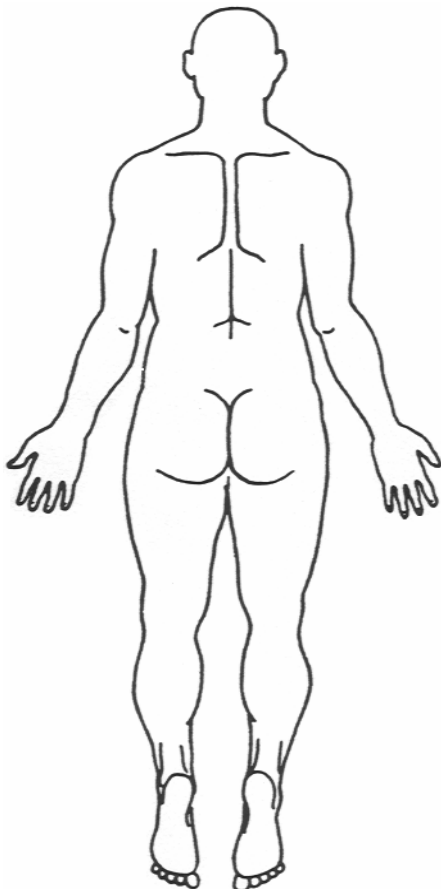
______________________________ ______________ ______________________________
Parent/Guardian's Authorizing Signature Date (MM/DD/YYYY) Witness' Signature

Who should receive bills for payment on this account? ____Parent ___Personal Health Ins. ___ Auto Ins.

DESCRIBE YOUR SYMPTOMS

Name ______________________ | # | Date ______________

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

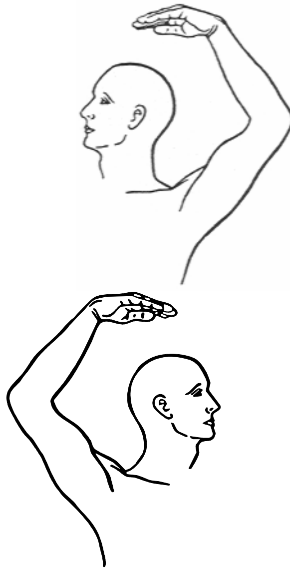


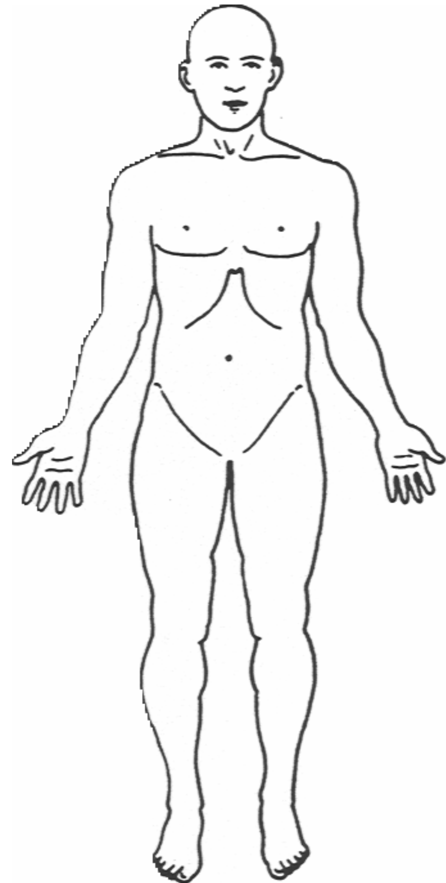
Sharp and Stabbing = + + + +

Dull and Achy = V V V V

Pins and Needles = 0 0 0 0

Numbness = / / / / / / /





Rate your activity level: Low Moderate High

Work Activity	Low	1	2	3	4	5	High
Pleasure Activity	Low	1	2	3	4	5	High

Check # below to rate your current pain level
#1 being almost pain free - #10 being Severe

C = Constant
I = Intermittent

Area of Pain	**Normal**		**Mild**			**Moderate**			**Severe**			**C**	**I**
Neck	0	1	2	3	4	5	6	7	8	9	10	C	I
Middle Back	0	1	2	3	4	5	6	7	8	9	10	C	I
Lower Back	0	1	2	3	4	5	6	7	8	9	10	C	I
Hip(s)	0	1	2	3	4	5	6	7	8	9	10	C	I
Shoulder(s) **Lft Rt**	0	1	2	3	4	5	6	7	8	9	10	C	I
Arm(s) **Lft Rt**	0	1	2	3	4	5	6	7	8	9	10	C	I
Leg(s) **Lft Rt**	0	1	2	3	4	5	6	7	8	9	10	C	I
Headaches	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I
Other:	0	1	2	3	4	5	6	7	8	9	10	C	I