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.

ABOUT THE PARENT

Name_____

Employer_____

Work phone_____ Cell phone_____

E-mail address _____

Social Security # _____

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 _____

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.

- ☐ Allergies
- ☐ Asthma
- ☐ Attention Problems
- ☐ Bed Wetting
- ☐ Breathing Problems
- ☐ Colic
- ☐ Constipation
- ☐ Digestive problems
- ☐ Ear Problems
- ☐ Frequent Colds
- ☐ Headaches
- ☐ Hyperactivity
- ☐ Irritability
- ☐ Skin Problems
- ☐ Sleep Disorders
- ☐ Ear Problems
- ☐ Tubes in ears
- ☐ Vision Problems
- ☐ Heart defect
- ☐ Surgeries_____

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

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:_____