CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Explain _____

Name				55 444	N 505			
Home PhoneBirthdate			DEAGON EOD IDIG MGH					
Age	Gender 🖵 M	ūΕ		Describe the purpose of this visit.				
Height	Weight		_					
Address				Is the purpose of this				
City/State/Zip				□ sports □ aut □ chronic discomf	ort 🗅 o	all 👊 home injury other		
Parent's Name			_	Explain				
Parent's Employer								
Parent's Work Phone				Has this condition				
Payment Method 🗅 Ca	ash 🗆 Check 🗅	Credit Card		gotten worse	a stayed con	stant 👊 comes and goes		
Crdt Cd. # exp				Does this condition interfere with				
				□ sleep □	a daily routin	e • other activities		
Health Insurance Co. Name Policy Number				Evnlain				
Policy Holder's Name				Has this condition occurred before? ☐ Yes ☐ No — Fixeleia				
Policy Holder's Social Security #								
Tolloy Holder 5 coolar co				Have you seen other	doctors for th	nis condition? 🗅 Yes 🗅 No		
				_				
MOTHER'S PR	EGNANCY & LA	BOR						
During pregnancy, did thetake any medication?		□ Yes						
Explain								
smoke or consume al	cohol? • No	□ Yes		CHILD'S	HEALTH	HISTORY		
experience any illness		☐ Yes	Dloo	na chook asch of the d	licaneae ar co	anditions that the child has		
Explain				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				
Approximately how long	did labor last?	hours				affect the overall diagnosis		
Was labor chemically ind		☐ Yes						
Was labor doctor assisted Was a C-Section perform		□ Yes □ Yes		Vision Problems		Pink Eye		
Was a 0-Section perform Were forceps or vacuum		☐ Yes		Headaches		Ear Problems		
Did the delivery doctor pu		_ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Sleeping Disorders		Tubes in the Ears Attention Problems		
baby during delivery?		☐ Yes		Irritability Skin Problems		Frequent Colds		
Was the delivery prematu	ire? 🗅 No	Yes		Allergies		Colic		
If "Yes", at	month and	weight		Breathing Problems		Digestive Problems		
Check any of the following if the child experienced it immediately after birth.				☐ Asthma ☐ Other				
□ Jaundice □ Respiratory Problems		ns		☐ Hyperactivity				
☐ Feeding Problems ☐ Displaced or Broken Joints			Bed Wetting					
Other Condition(s)				_ Jug				

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone?	J No ☐ Yes	S	GUALS FUR MY CH	ILD 3 CAKE			
Has your child:		Сh	ildren see Chironractors for a varie	ety of reasons. Some			
been hospitalized?	No コYes No コYes)	Children see Chiropractors for a variety of reasons. So go for relief of pain, some to correct the cause of pain				
had a severe fall?	S	others for correction of whatever is malfunctioning in their					
been in a car accident?	□ No □ Yes	S ho	bodies. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care				
Has your child ever taken antibiotics? If "Yes", explain	⊃ No ⊃ Yes	s wh					
Is your child <u>currently</u> taking any medication?		program. Please check the type of care desired so that we may be guided by your wishes whenever possible.					
If "Yes, explain			Relief Care — Symptomatic rel	ief of pain or			
Does your child have difficulty interacting with			discomfort				
friends?	Yes L No	IJ.	Gerrective Care — Correcting and relieving the cause of the problem as well as the symptoms				
Have you or anyone else noticed that your chi			Comprehensive Care — Bring v				
twitches, shakes or exhibits rooking behavior		5	eather finning in the budy to th	oudy to the highest state of			
What changes (if any) in your chaid's dealth o			Castin passable with Othropractic				
like accomplished?	-	(1)	count the Bodier ic edect the ty made daily	rpe of care appropriate			
			Parent/Guardian's Signature	Date			
	VAC	CINATION	5				
Have you chosen to vaccinate your child DPT MMR Polio Describe any and all reactions to vaccin	Chicken Pox	d → Hepatiti	s 🗀 Other				
AUTHORIZA	ATION TO	CARE FO	R A MINOR CHILD				
I hereby authorize the Doctors in this Chirop Chiropractic care, to work with my child (nar the spine, as the Doctor deems appropriate.	me)						
I clearly understand and agree that all service I agree that I am responsible for all bills incu diagnosed conditions nor for any medical dia for professional services rendered will become	rred at this office. agnosis. I also un	The Doctor will derstand that if m	not be held responsible for any pre	e-existing medically			
I understand and agree that health and accid holder. I understand that the Doctor's Office insurance company and that any amount aut receipt. I hereby authorize assignment of ins my child.	will prepare any r thorized to be paid	necessary reports directly to the Do	and forms to assist me in collecti octor's Office will be credited to m	ng from the y account on			
Patient's Name (Print)			Parent or Legal Guardian's Name (Print)				
Parent/Guardian's Signature Authorizing Care	Date (N	M/D/Y)	Witness' Signature				
Who should receive bills for payment on t	his account?						
□ Parent □ Personal Hea	Ith Insurance	Auto Insur د	ance 🗀 Medicare	→ Medicaid			