CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name_____
Home Phone_____
Age____ Date of Birth_____ Gender □ M □ F
Height_____
Address_____
City/State/Zip_____
Parent's Name _____
Parent's Employer _____
Parent's Work Phone_____
Health Insurance Co. _____
Policy Number_____
Policy Holder's Name_____
Policy Holder's Address
_____
_____

MOTHER'S PREGNANCY & LABOR

During Pregnancy, did the 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 the 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 or Broken Joints
□ Other condition(s) _____

REASON FOR THIS VISIT

Describe the purpose for this visit. _____

_____

_____

Is the purpose of this appointment related to:

□ Sports □ Auto □ Fall □ Home Injury

□ Chronic Discomfort □ Other _____

_____

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 _____

Has this condition occurred before? □ No □ Yes

Explain _____

Have you seen others for this condition? □ No □ Yes

Who? _____
Treatment? _____
Results? _____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has no 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
□ Hyperactivity
□ Constipation
□ Bed Wetting
□ Pink Eye
□ Ear Problems
□ Tubes in the Ears
□ Attention Problems
□ Frequent Colds
□ Colic
□ Digestive Problems
□ Other _____
_____
_____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? □ No □ Yes
Has your child:
…been hospitalized? □ No □ Yes
…had a sever fall? □ No □ Yes
Has your child ever taken antibiotics? □ No □ Yes

If "Yes", explain _____
Is your child currently taking any medication? □ No □ Yes

If "Yes", explain_____
Does your child have difficulty interacting with schoolmates or friends? □ No □ Yes
Gave 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? _____

VACCINATIONS

Have you chosen to vaccinate your child? □ No □ Yes

If "Yes", check all that apply

□ DPT □ MMR □ Polio □ Chick Pox

□ Hepatitis □ Other _____

Describe any and all reactions to vaccine(s). _____

_____

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 you needs and desires when recommending your child's chiropractic care program. Please check the type of care desired so that we may be 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

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the doctors of In Motion Chiropractic 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.

Insurance:
I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.
Non-insurance:
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.

_____
Patient's Name (print)

_____
Parent of Legal Guardian's Name (print)

_____
Parent or Guardian's signature Authorizing Care

_____
Date (M/D/Y)

_____
Witness's Signature

Who Should receive payment on this Account?

□ Parent

□ Personal Health Insurance

□ Auto Insurance

□ Medicare