CHILDREN'S HEALTH RECORD

About the Child

Name ______________________________________

Home Phone________________ DOB ___________

Age ___________ Gender ☐ M ☐ F

Height __________ Weight______________

Address ______________________________________

City/State/Zip __________________________________

Parent's Name _________________________________

Parent's Employer ______________________________

Parent's Work Phone ___________________________

Parents Email Address___________________________

Payment Method ☐Cash ☐Check ☐Credit Card

Crdt Cd. # _________________________ exp_________

Health Insurance Co. Name ______________________

Policy Holders Social Security # ___________________

Mother's Pregnancy & Labor

During the pregnancy, did the mother:

.... take any medication? ☐ No ☐ Yes

Explain __________________________________

.... smoke or consume alcohol? ☐ No ☐ Yes

……..experience any illness? ☐ No ☐ Yes

Explain __________________________________

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 ________ weeks 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)

Explain __________________________________

Reason for this Visit

☐ Wellness ☐ Specific Condition

Describe the purpose of this visit. ________________________

____

Is the purpose of this appointment 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 ____

Has the condition occurred before? ☐ No ☐ Yes

Explain____

Have you seen other doctors for this condition ☐ No ☐ Yes

Dr.'s Name(s) __________________________________

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 course of care for your child.

☐ Vision Problems ☐ Pink Eye

☐ Headaches ☐ Ear Problems

☐ Sleeping Disorders ☐ Tubes in Ears

☐ Irritability ☐ Attention Problems

☐ Skin Problems ☐ Frequent Colds

☐ Allergies ☐ Colic

☐ Breathing Problems ☐ Digestive Problems

☐ Asthma ☐ Hyperactivity

☐ Constipation ☐ Bed Wetting

Other____

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 <u>currently</u> taking any 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 the 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 be guided by your wished 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

☐ **Wellness Care**- Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

☐ I want my 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

☐ CDC Recommended Schedule Additional____

☐ Delayed Vaccination Schedule

☐ Other _______________

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

Thank you for choosing Superior Chiropractic!

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