

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.

- | | |
|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Pink Eye |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Sleeping Disorders | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> 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 currently 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 you 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!

906.482.2400

www.SuperiorFamilyChiropractic.com