CHILDREN'S HEALTH RECORD

SUPERIOR FAMILY CHIROPRACTIC

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Chassell, MI 49916
(906) 482-2400
www.superiorfamilychiropractic.com

Child's Name _____

Home Phone _____ Gender ❑ M ❑ F

Birth Date _____ Age _____

Height _____ Weight _____

Address _____

City, State, Zip _____

Parent Name(s) _____

Cell Phone(s) _____

Work Phone _____

Employer _____

email _____

Payment ❑ Cash ❑ Check ❑ Credit Card ❑ Care Credit ❑ HSA/FSA

Insurance Co. _____

Policy Holder's SS# _____

MOTHER'S PREGNANCY & LABOR

During the pregnancy, did the mother:

Take any medication? ..... ❑ No ..... ❑ Yes

If yes, explain _____

Smoke or consume alcohol? ..... ❑ No ..... ❑ Yes

Experience any illness? ..... ❑ No ..... ❑ Yes

If yes, explain _____

History of Birth

Weeks of gestation _____

Birth Weight _____ Length _____

Labor time (hrs) _____ Pushing time (mins) _____

Was labor chemically induced? ..... ❑ No ..... ❑ Yes

C-Section? ..... ❑ No ..... ❑ Yes

Forceps or vacuum extraction? ..... ❑ No ..... ❑ Yes

Was baby twisted or pulled during delivery? ..... ❑ No ..... ❑ Yes

Did baby experience any of the following immediately after birth?

❑ Jaundice ❑ Respiratory problems

❑ Feeding problems ❑ Displaced or broken joints

❑ Other / explain _____

REASON FOR THIS VISIT

❑ Wellness ❑ Sports Injury

❑ Auto Injury ❑ Fall

❑ Home injury ❑ Chronic Discomfort

❑ Other / describe _____

_____

When did this condition begin? _____

This condition has:
❑ Gotten worse
❑ Stayed constant
❑ Comes and goes

Condition interferes with:
❑ Sleep
❑ Daily routine
❑ Other activities

Explain _____

Has the condition occurred before? .... ❑ No .... ❑ Yes

If yes, explain _____

Have you seen other doctors for this condition? ..... ❑ No .... ❑ Yes

Dr. Name(s) _____

_____

Type of treatment _____

_____

Results _____

_____

Please complete other side

CHILD'S CURRENT HEALTH STATUS

Is child accident prone? ..... ❑ No ..❑ Yes

Has child ever been hospitalized?..... ❑ No ..❑ Yes

Has child ever had a severe fall? ..... ❑ No ..❑ Yes

Has child ever broken a bone, sprain etc.? ❑ No ❑ Yes

Has child ever been in a car accident?..... ❑ No ..❑ Yes

Has child ever taken antibiotics? ..... ❑ No ..❑ Yes

If yes, explain _____

Is child currently taking medication?.....❑ No.....❑ Yes

If yes, explain _____

Have you noticed that child is nervous, twitches, shakes or exhibits rocking behavior?.....❑ No.....❑ Yes

What changes (if any) in child's health or behavior would you like to see? _____

_____

_____

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 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.

❑ **Relief Care:** Symptomatic relief of pain or discomfort.

❑ **Wellness Care:** Curing 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.

SUPERIOR
FAMILY CHIROPRACTIC

CHILD'S HEALTH HISTORY

Please mark conditions or problems this child has or had. While they may seem unrelated to the purpose of the appointment, they can affect the overall course of care.

❑ Allergies
❑ Attention deficit
❑ Breathing
❑ Asthma
❑ Bed Wetting
❑ Colic
❑ Constipation
❑ Digestion
❑ Ear Infections/Tubes
❑ Frequent colds
❑ Headaches
❑ Head Injury
❑ Hyperactivity
❑ Irritability
❑ Pink Eye
❑ Scoliosis
❑ Skin
❑ Sleeping
❑ Tongue/Lip Tie
❑ Vision

❑ Other _____

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).

_____

NOTES