HEALTH HISTORY

Child 0-12years

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential)

Date:____/____/____

Name:_____ Referred By:_____
Address:_____City:_____
State:_____ Zip:_____ Home Phone(_____)_____
D.O.B.____/____/____ Sex: M F Age:_____
Parents names:_____
E-mail address:_____

Are you seeking chiropractic for your child today as a regular health check up? Yes ( ) No ( )
Has your child ever been under chiropractic care before? Yes ( ) No ( )
Does your child have any health problems we need to know about? Yes ( ) No ( ) If yes please list the problems. _____
_____
How long has your child had this problem? _____ Date problem began ____/____/____
Has your child had a similar condition before? Yes ( ) No ( ) When: ____/____/____
Is the problem related to an accident? Yes ( ) No ( ) If yes what happened? _____
_____
_____
Has your child had any surgeries? Yes ( ) No ( ) If yes what surgeries? _____
_____
Does your child take any medications? Yes ( ) No ( ) If yes what medications? _____
_____
Has your child been vaccinated? Yes ( ) No ( )
Is there anything else we need to know about your child? Yes ( ) No ( ) If yes what? __
_____
_____

HEALTH FUTURE

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to raise a healthy child?)_____
_____
_____
Do you do anything to insure that your child's nerve system is functioning properly? Yes ( ) No ( ) If yes what? _____
_____
Does your child get daily exercise? Yes ( ) No ( ) If yes what exercise does your child get? _____
_____

Does your child take any natural supplements, vitamins, minerals, ect.? Yes ( ) No ( )
If yes what? _____
_____
What is your child's diet like? (What does your child eat, whole foods, organic, vegetables, junk food, ect.?_____
_____
_____
Was or is your child breast feed? Yes ( ) No ( )
Does your child have a great attitude? Yes ( ) No ( )

On a scale of 1-10 (10 being the best health and 1 being the poorest health) where would you rate the health of the following?

Your child:	1 2 3 4 5 6 7 8 9 10
Your child's father:	1 2 3 4 5 6 7 8 9 10
Your child's mother:	1 2 3 4 5 6 7 8 9 10
Your child's siblings:	1 2 3 4 5 6 7 8 9 10

HOW WOULD YOU LIKE US TO HANDLE YOUR CHILD'S CHIROPRACTIC CARE?

____Relief Care (weeks)	(help the symptoms but do not fix the cause of the problem)
____Health Care (months)	(correct the cause of the problem and stabilize the spine)
____Wellness (lifetime)	(Correct the cause of the problem and continue into life time wellness care to optimize quality of life as your child grows)

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Child's signature if able:_____

Parent or Guardian's signature:_____

Consent to take care of a minor child a t Performing Edge Chiropractic

I hereby authorize the doctors at Performing Edge Chiropractic and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship of child),
Child's name: _____,
Dated at Attica, Ohio this _____ day of _____, 20_____

Signed:_____
(Parent or guardian)

Witnessed: _____