

Children's Health Record

To be completed for all children under the age of 18

Child Information

Name: _____

Birthdate: _____

Nickname: _____

Gender: Male Female

Height _____ Weight: _____

Parent/Guardian's Information:

Name: _____

Address: _____

City/St/Zip: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Payment Information:

Method: Cash Check Credit Card

Credit Acct # _____ exp _____

Health Insurance Comp _____

Policy Number _____

Policy Holder Name: _____

Policy Holder Social Security # _____

Purpose for visit

Describe the reason for this visit:

How long has your child experienced this problem?

Was this problem the result of

Has it gotten better or worse over time?

Better Worse About the same comes and goes

Other health care professionals consulted for this problem

Name: _____ Type: _____

Name: _____ Type: _____

Name: _____ Type: _____

Are you content with the overall health of your child? Yes No

Health History

Has the child ever had any of the following problems?

- | | |
|--|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Vision impairment | <input type="checkbox"/> Back Pains |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pains | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sinus Troubles |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Eczema / Skin Problems | <input type="checkbox"/> Growing Pain |
| <input type="checkbox"/> Bronchitis / Upper Respiratory Infections | |

Other _____

Is your child currently taking any medication?

Yes No

If "yes" please list medications and reason:

Has your child ever taken antibiotics? Yes No

If "yes" please explain:

Check the vaccinations the child has received:

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> DPT | <input type="checkbox"/> Measles |
| <input type="checkbox"/> MMR | <input type="checkbox"/> Chicken Pos |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other: _____ | |

Pre-natal / Mother's Health History

During pregnancy, did the child's mother:

- | | | |
|---|------------------------------|-----------------------------|
| Take any medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, explain: | | |
| Smoke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Consume alcohol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experience any illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was labor chemically induced? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was labor doctor-assisted? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was a C-Section performed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Were forceps or vacuum extraction used? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was the delivery premature? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

AUTHORIZATION FOR CARE OF MINOR

I / We, the undersigned parent(s) and/or guardian(s) of

_____ SS#: _____ - _____ - _____, a

minor, do hereby authorize this office and its doctors to administer chiropractic care to my child, as they deem necessary.

Parent or legal guardian's name (please print)

Parent or legal guardian's signature

Witness's signature

Date

Agreement for Payment of Services

By signing the authorization above I affirm that I understand and agree that:

- health and accident insurance policies are an arrangement between patients and their insurance carriers;
- this office will prepare any necessary reports and forms to assist me in making collection from the insurance company;
- any amount that is authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account;
- all services rendered to me are charged directly to me and that I am personally responsible for the payment of my account; and
- it is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made.