Denn Chiropractic Clinic LLC

475 Chippewa Mall Dr. Ste.155, Chippewa Falls, WI 54729
Phone: 715-726-0400 / Fax: 715-726-0422

Youth Health history form

Patient information:
Date:_____
Childs Name:_____ M / F Date of birth: ____/_____/_____
Parent/Guardian Name:_____ Relation to child:_____

==========

Medical History:

Pediatrician/Family MD:_____
Has your child been vaccinated? Yes_____ No_____ Are they up to date? Yes_____ No_____
Does your child take any medications/vitamins? Yes_____ No_____
If yes, please list_____
Has your child ever had chiropractic care? Yes_____ No____ If yes, when _____
Reason for previous chiropractic care_____

Child's health history:

Please indicate each of the following that your child has now or in the past had:

___Allergies ___Asthma ___Autism ___Back pain ___Hives ___Hay fever
___Headaches ___Bed wetting ___ADHD ___Frequents colds ___Eczema ___Sleeping problems
___Colic ___Ear Infections ___Falls/Injury ___Sports Injury ___Stomach pain ___Excess vomiting
___Scoliosis ___Neck pain ___Diarrhea ___Growing pains ___Poor eating ___Car accident
___Fractures ___Low back pain ___Fevers ___Constipation ___Rapid weight loss/gain

Daily habits and activities: Does your child participate in any of the following (please circle)
Soccer Football Gymnastics Karate Hockey Lacrosse Basketball Wrestling Baseball Softball Tennis Dance Volleyball Swimming
*Other sport/activities:*_____

Reason for this visit?_____ **When did it begin?** _____

Please describe the pain:
___dull ___sharp ___achy
___frequently
___numb ___burning ___tingling
___intermittent
___stabbing ___shooting ___radiating

How often are the symptoms:
___constantly
___occasionally
___coming/going ___periodically

Are the symptoms changing?
___better ___same ___getting worse

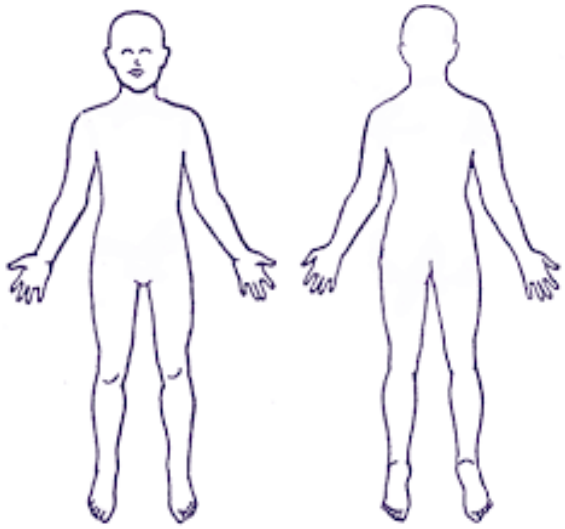
Has the child had these symptoms before? Yes / No
If yes when_____

Please grade your symptoms:
(0=no pain) (10=severe pain)
0 1 2 3 4 5 6 7 8 9 10

Please circle areas of symptoms

Is there anything that aggravates the condition ? (Please Circle)
Bending / Lifting / Twisting / Pushing / Pulling / Sitting
Standing / Exercise / Sleeping / Computer/ Video games
*Other*_____

Is there anything that relieves the condition?
(Please Circle)
Icing / Heating pad / Resting / Lying down / Medications
Sitting / Standing / Exercise / Bio-freeze / Icy hot gel
Other_____



==========

==========**Authorizations & consent to treat:**

Being the parent or legal guardian of this child, I hereby authorize this office and Dr. Denn to examine and administer care to my child as the examining and treating doctor deems necessary. If any x-ray films need to be taken, they will remain the property of this office. I understand and agree that I am personally responsible for payments of all fees charged by this office for any such care that myself/ insurance companies deem not medically necessary. Any returned checks are subject to a $35.00 service charge. I hereby authorize assignment of my insurance rights and benefits ,if applicable to the provider for services rendered. I further understand that this consent is open and non-ending.

Child's name:_____ Relation to child:_____
Parent/Guardian's name:_____
Date:_____
Witnessed by:_____
Date:_____