



Rockwall Health Center
2880 Ridge Rd
Rockwall, TX 75032
(469) 769-1009

YOUNG ADULT PATIENT HEALTH RECORD

PATIENT NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	WEIGHT:

PARENTS/LEGAL GUARDIANS NAMES:	
ARE YOU THE PARENT OR LEGAL GUARDIAN: <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

WHO REFERRED YOU TO OUR OFFICE?	
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (LIST ALL THAT APPLY) <input type="checkbox"/> ONLINE <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING	
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	

NUMBER OF DOSES OF PRESCRIPTION MEDICATION CHILD HAS TAKEN DURING HIS/HER LIFETIME:
PLEASE LIST ALL MEDICATIONS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S):

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> WELLNESS <input type="checkbox"/> CONDITION IF CONDITION, DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN:
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GO
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

INSTRUCTIONS: Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

- | | |
|--|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> BACK PAIN/STIFFNESS | <input type="checkbox"/> DIFFICULT/PAINFUL/IRREGULAR PERIODS |
| <input type="checkbox"/> BED WETTING | <input type="checkbox"/> DIFFICULT WEIGHT GAIN |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> EAR INFECTIONS |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> FREQUENT COLDS, COUGHS, ETC. |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SHOULDERS/ELBOW/WRIST |
| <input type="checkbox"/> HYPERACTIVITY | <input type="checkbox"/> SLEEPING PROBLEMS |
| <input type="checkbox"/> HIPS/KNEE/ANKLES | <input type="checkbox"/> SORE THROAT |
| <input type="checkbox"/> LEARNING DISORDERS | <input type="checkbox"/> STRESS |
| <input type="checkbox"/> NECK STIFFNESS/PAIN | <input type="checkbox"/> UPSET STOMACH |
| <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> URINARY INFECTIONS |

DURING PREGNANCY DID YOU USE:

- DRUGS/MEDICATIONS TOBACCO/ALCOHOL

IF YES, PLEASE LIST:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?

- YES NO

PLEASE EXPLAIN:

ULTRASOUND DURING PREGNANCY?

- YES NO NUMBER:

LOCATION OF BIRTH:

- HOME BIRTHING CENTER HOSPITAL

DESCRIBE YOUR DELIVERY:

- LABOR WAS CHEMICALLY INDUCED
 LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY
 FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY
 PREMATURE DELIVERY

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT: _____

BIRTH LENGTH: _____

APGAR SCORES: _____

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

DID YOU BREASTFEED THE BABY?

YES NO

IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY?

YES NO

IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS: _____

COW'S MILK: _____

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

YES NO

DOES YOUR CHILD EXERCISE DAILY?

YES NO

HOW MUCH?

DOES YOUR CHILD DRINK SODA?

YES NO

HOW MUCH?

DOES YOUR CHILD TAKE VITAMINS?

YES NO

DOES YOUR CHILD DO AFFIRMATIONS?

YES NO

DOES YOUR CHILD HAVE DIFFICULTY SLEEPING?

YES NO

EXPLAIN:

DOES YOUR CHILD PLAY VIDEO GAMES?

YES NO

HOW MUCH?

DOES YOUR CHILD WATCH MORE THAN AN HOUR OF TV PER DAY?

YES NO

HOW MUCH?

DOES YOUR CHILD EAT BALANCED MEALS?

YES NO

DOES YOUR CHILD EXPERIENCE PROLONGED SADNESS?

YES NO

EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E. BED, CHANGING TABLE, STAIRS, ETC).

WAS THIS THE CASE FOR YOUR CHILD?

YES NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?

YES NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?

YES NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

YES NO

PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

YES NO

PLEASE EXPLAIN:

PLEASE RATE STRESS LEVEL ON A SCALE OF 1-10 (10 BEING HIGH)

SCHOOL: 1 2 3 4 5 6 7 8 9 10

PERSONAL: 1 2 3 4 5 6 7 8 9 10

AUTHORIZATION FOR CARE OF A MINOR

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing. I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care. To work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered will become immediately due and payable.

PARENT OR GUARDIAN SIGNATURE:

DATE: