WHITE ROSE FAMILY CHIROPRACTIC, LLC

Child Heath History Form

PATIENT INFORMATION

Child's Name_____ Parent (s) Guardian Name _____

Address _____ City _____State_____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone_____

Is it alright to contact you at work ? Yes □ No □

E–mail _____ Birthdate _____ Age _____

Have you or your child ever had chiropractic care before? Yes □ No □

If yes, please tell us the doctor's name _____

Were you pleased with your care? Yes □ No □

How did you find out about our office? _____

Is this appointment wellness or conditioned based _____

Is your child receiving care from other health professionals? Yes □ No □

If yes please name their specialty _____

Who is your family's primary care physician? _____

Please list and drugs or medications your child is taking

_____

Please list any vitamins/herbs/homeopaths/other your child is taking

_____

Please list any allergies your child has

_____

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CURRENT HEALTH

What health or wellness visit brings your child to our office? If wellness, skip to (*)

_____

_____

What, if any did the symptoms first begin?

_____

How did the problem start ? Suddenly □ Gradually □ Post-Injury □

Is this condition □ Getting Worse □ Improving □ Intermittent □ Constant □ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? □ Yes □ No

If yes, please explain _____

Has your child been treated for this problem before? □ Yes □ No

If yes, please explain _____

(*) Does your child eat well? □Yes □No

HEALTH HISTORY

Child's birth was □ At Home □ At a birthing center □ At a hospital

My obstetrician/midwife/family physician was _____

Child birth was □ Natural vaginal (no medications/inverventions)
□ Vaginal with interventions
□ Induction □ Pain medication □ Epidural □ Epsiotomy □ Vacuum extraction □ Forceps

□ Other _____

□ C-section □ Scheduled □ Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Child's birth height_____
Child's current weight _____ Child's current height_____

APGAR score at birth _____ APGAR score after 5 minutes _____

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WHITE ROSE FAMILY CHIROPRACTIC, LLC

Was your child alert and responsive within 12 hours of delivery? □ Yes □ No

If no, please explain _____

At what age did the child :

Respond to sound _____ Follow an object_____ Hold head up _____

Vocalize _____ Sit alone _____ Teethe_____ Crawl _____

Walk _____

GROWTH & DEVELOPMENT

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations including the year)

_____

_____

Please list any injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including this year whether how minute it may seem.

_____

_____

Is/was your child breastfed? □Yes □ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any food/juice intolerance _____

Did mother smoke during pregnancy? □ Yes □ No

Did mother drink alcohol during pregnancy? □ Yes □ No

Any illness of mother during pregnancy? □ Yes □ No

If yes, please explain including treatment/medications/supplements

_____

List any drugs/medications/supplements (including over the counter) taken during pregnancy _____

_____

Any exposures to ultrasound? □ Yes □ No If so, how many and what was the medical reason? _____

_____

Any pets at home □ Yes □ No Any smokers at home? □ Yes □ No

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GROWTH & DEVELOPMENT CONTINUED

Has your child received any vaccinations? □ Yes □ No

If yes, which ones and list any reactions _____

_____

Has your child received any antibiotics □ Yes □ No If yes, how many time and list reasons

_____

_____

Any difficulty with breastfeeding? □ Yes □ No If yes, please explain _____

_____

Any difficulty with bonding? □ Yes □ No If yes, please explain _____

_____

Any behavioral problems? □ Yes □ No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping □ Yes □ No If yes, please explain

_____

_____

Age child began daycare _____ Average number of hours of TV per week _____

FAMILY HISTORY REVIEW

Does your child act age appropriate □ Yes □ No If no, please explain _____

_____

□ Cancer, type _____ □ M □ F □ S □ G	□ Depression □ M □ F □ S □ G	□ Diabetes □ M □ F □ S □ G	□ Back Problems □ M □ F □ S □ G
□ Heart Disease □ M □ F □ S □ G	□ Liver Disease □ M □ F □ S □ G	□ High Blood Pressure □ M □ F □ S □ G	□ High Cholesterol □ M □ F □ S □ G
□ Lung Problems □ M □ F □ S □ G	□ Scoliosis □ M □ F □ S □ G	□ Neck Problems □ M □ F □ S □ G	□ Osteoporosis □ M □ F □ S □ G
□ Seizures □ M □ F □ S □ G	□ Osteoarthritis □ M □ F □ S □ G	Rheumatoid Arthritis □ M □ F □ S □ G	

Check those involving immediate family and add identification: M=Mother; F=Father; S= Sibling G= Grand-P

DO YOU KNOW ABOUT CHIROPRACTIC

WHITE ROSE FAMILY CHIROPRACTIC, LLC

Do you know what a subluxation is? □ Yes □ No

Do any of your friends or relatives see a chiropractor? □ Yes □ No

If yes, do they use chiropractic for □ Health Maintenance/optimization □ Health Problems □ Both

Are you seeking a chiropractor □ Health Maintenance/optimization □ Health Problems □ Both

What would you like to gain from chiropractic care for your child?

_____

_____

CONSENT TO TREAT A MINOR

(I) (We), the undersigned, parent(s) / person having legal custody / legal guardianship of

_____, a minor, so hereby authorize
(name of Minor)

_____, as agent (s) for the undersigned
(name of Agent)

To consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent (s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his / her best judgment, deem advisable.

This authorization shall remain effective until _____, 20 _____
(Month and Date) (year)

Unless sooner revoked in writing delivered to the agent (s) noted above.

Date:_____

Signature: _____
(Parent / Legal guardian having legal custody) (circle relationship)

Signature: _____
(Parent)