PEDIATRIC HEALTH RECORD

ABOUT YOUR CHILD

NAME:

PARENT(S)/GUARDIAN(S) NAME:

ADDRESS:

CITY:	STATE AND ZIP CODE:
HOME PHONE:	PARENT'S CELL PHONE:

PARENT'S EMAIL ADDRESS:

MAY WE LEAVE A MESSAGE AT HOME REGARDING YOUR CHILD'S CARE?
❑ YES ❑ NO, OR REGARDING YOUR APPOINTMENT? ❑ YES ❑ NO

DATE OF BIRTH/AGE:	GENDER:

HOW DID YOU HEAR ABOUT OUR OFFICE?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IF THERE ARE SYMPTOMS, WHEN DID THEY FIRST BEGIN?

HOW DID THE PROBLEM START? SUDDENLY / GRADUALLY / POST-INJURY?

IS THE CONDITION: GETTING WORSE / IMPROVING / INTERMITTENT / CONSTANT / NOT SURE

WHAT MAKES THE PROBLEM BETTER?

WHAT MAKES THE PROBLEM WORSE?

DOES THIS CONDITION INTERFERE WITH:
SLEEP / SCHOOL / DAILY ROUTINE / MEALS / SOCIAL OUTINGS / FAMILY EASE OR OTHER ACTIVITES?

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SIMILAR CONDITION? YES / NO
PLEASE EXPLAIN:

HAS YOUR CHILD RECEIVED CARE FROM OTHER PROFESSIONALS FOR THIS CONCERN? YES / NO

PLEASE TELL US WHO AND SPECIALTY:

BIRTH HISTORY

CHILD'S BIRTH WAS: HOME / BIRTHING CENTER / HOSPITAL

CHILD'S BIRTH WAS:
A. NATURAL VAGINAL (NO MEDICATIONS/INTERVENTIONS)
B. VAGINAL WITH INTERVENTIONS: INDUCTION / PAIN MEDS / EPIDURAL EPISOTOMY / VACUUM EXTRACTION / FORCEPS / OTHER
C. C-SECTION: SCHEDULED / EMERGENCY

DELIVERY: DID THE DOCTOR PULL OR TWIST THE BABY ? YES / NO / UNSURE

PLEASE LIST REASONS FOR ANY INTERVENTIONS / COMPLICATIONS:

CHILD'S BIRTH WEIGHT / HEIGHT:
CHILD'S CURRENT WEIGHT / HEIGHT:

HOW LONG WAS LABOR?
HOW LONG WAS THE DELIVERY?

DID MOTHER HAVE A DIFFICULT TIME CONCEIVING?
IF YES, PLEASE EXPLAIN (INCLUDE TREATMENT):

ANY ILLNESS OF MOTHER DURING PREGNANCY? YES / NO
IF YES, PLEASE EXPLAIN (INCLUDE TREATMENT):

LIST ANY MEDICATIONS , VACCINATIONS AND SUPPLEMENTS TAKEN DURING PREGNANCY (IF NOT LISTED ABOVE) AND FOR WHAT REASON:

WAS YOUR BABY EVER BREECH? YES/ NO/ UNSURE
DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? YES / NO
IF YES, HOW MANY_______

WAS THE MOTHER UNDER HIGH STRESS OR HAVE ANXIETY DURING THE PREGNANCY? YES / NO

GROWTH AND DEVELOPMENT

WAS YOUR CHILD ALERT AND RESPONSIVE WITHIN 12 HOURS OF DELIVERY? YES / NO

IF NO, PLEASE EXPLAIN:

HOSPITALIZATION/SURGICAL HISTORY (PLEASE INCLUDE YEAR):

PLEASE LIST ANY MAJOR INJURIES, ACCIDENTS, FALLS, AND/OR FRACTURES:

IS/WAS YOUR CHILD BREASTFED? YES / NO
IF YES, HOW LONG?
ANY DIFFICULTY WITH BREASTFEEDING? YES / NO ________________________
DID YOUR CHILD HAVE COLIC? YES / NO
WAS YOUR CHILD DIAGNOSED WITH ACID REFLUX? YES / NO

WAS FORMULA EVER INTRODUCED?
AT WHAT AGE?
WHAT TYPE?

GROWTH AND DEVELOPMENT

WAS COW'S MILK INTRODUCED? YES/ NO AT WHAT AGE:________

BEGAN SOLID FOODS AT AGE:

HAS YOUR CHILD RECEIVED ANY VACCINATIONS? ALL / MOST / SOME / NONE
NOTES:____

REACTIONS: FEVER / SICKNESS / FUSSINESS / SEIZURES / LETHARGY / SWELLING
OTHER:____

____

HAS YOUR CHILD RECIVED ANY ANTIBIOTICS? YES / NO
IF YES, HOW MANY TIMES AND LIST REASON:

DOES YOUR CHILD HAVE ANY BEHAVIORAL PROBLEMS? YES / NO
IF YES, PLEASE EXPLAIN:

DOES /DID YOUR CHILD HAVE DIFFICULTY WITH BONDING? YES / NO
IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE NIGHT TERRORS, SLEEPWALKING OR DIFFICULTY SLEEPING? YES / NO
IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD SEEM TO BE DEVELOPING AT THE SAME RATE AS THEIR PEERS? YES / NO
IF NO, PLEASE EXPLAIN:

HOW WOULD YOU DESCRIBE YOUR CHILD'S DIET?

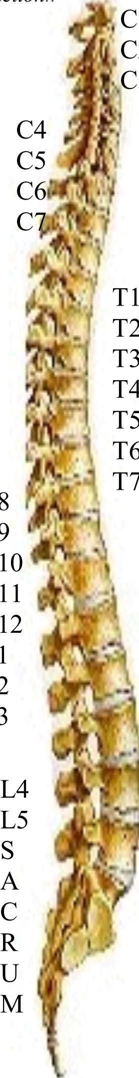
DOES YOUR CHILD HAVE REGULAR BOWEL/BLADDER MOVEMENTS? YES / NO

AVERAGE NUMBER OF HOURS OF TV/ELECTRONICS PER WEEK:

PLEASE LIST ANY ALLERGIES YOUR CHILD HAS:

YOUR CONCERNS

INSTRUCTIONS: *Please* ***circle*** *the health concerns or conditions your child may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function..*



Headaches/Migraines
ADD/ADHD
Sensory/Spectrum Disorder
Insomnia
Reflux/GI Issues
Ear Infections/Aches
Vision Problems
Sinus Trouble/Allergies
Colic/Irritability
Anxiety
Balance/Coordination Issues
Acne/Eczema
Epilepsy/Seizure

Runny Nose
Swollen Adenoids
Laryngitis/Strep/Sore Throat
Tonsillitis
Croup
Chronic Cough
Thyroid Issues
Poor Weight Regulation
Stiff Neck and Shoulders
Numbness Tingling
Hay Fever

Asthma
Cough/Cold
Breathing Trouble
Heart Conditions
Chest Pain
Bronchitis
Pneumonia
Congestion
Chronic Colds/Flu
Reflux/GERD
Fever
Stomach Problems: Pain/
Indigestion/Ulcers
Liver Problems

Allergies
Immunity Issues: sickness
Hyperactivity
Kidney Troubles
Constipation/Gas Pains
Irritable Bowel Syndrome
Colitis
Abdominal Cramps
Diarrhea
Bladder Issues
Acne/Rash/Eczema
Fatigue

Constipation
Bedwetting/ accidents
Sciatic/Leg Pain
Weak Ankles/Arches
Difficult, Painful or
Frequent Urination
Foot/Ankle/Knee Pain
Low Back Pain
Spinal Curvatures

OTHER:

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MEDICATIONS/ SUPPLEMENTS

PLEASE LIST ANY VITAMINS/HERBS/HOMEOPATHIES YOUR CHILD IS TAKING:

PLEASE LIST ANY DRUGS OR MEDICATIONS YOUR CHILD IS TAKING:

GOALS FOR YOUR CARE

A LARGE NUMBER OF THE KIDS WE SEE IN OUR OFFICE ARE HERE FOR WELLNESS CARE. HOWEVER, PEOPLE CHOOSE TO SEE A PEDIATRIC CHIROPRACTOR FOR A VARIETY OF REASONS.

WHAT WOULD YOU LIKE TO GAIN FROM CHIROPRACTIC CARE?

FAMILY HISTORY REVIEW

Circle those involving immediate family and add identification: M=Mother, F=Father, S=Sibling, G=Grandparent

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	Other __________________________

AUTHORIZATION FOR CARE OF A MINOR

I, _______________________hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child, to work with their condition through the use of adjustments and procedures the doctor deems appropriate.

TERMS OF ACCEPTANCE

It is essential to understand that the patient and the Doctor have the same objective. To prevent any confusion, it is important to understand that chiropractic has one main goal. Our only objective is to eliminate an interference to the expression of the body's innate wisdom by providing specific adjustments to correct vertebral subluxations. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of an evaluation, we encounter non-chiropractic findings, we will advise you. Regardless of what diagnoses you may have been given by other professionals we do not offer to treat it, nor will we offer advice regarding their treatment prescribed.

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I clearly understand and agree that all services rendered to me 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 and understand that DC Wellness Center does not bill to insurance for reimbursement. 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 me will become immediately due and payable.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PARENT OR GUARDIAN AURTHORIZING CARE SIGNATURE	RELATIONSHIP TO PATIENT:
PARENT OR GUARDIAN AUTHORIZING CARE NAME PRINTED	DATE:

DC Wellness Center
9479 Garland Lane North
Maple Grove, MN 55311
763-494-8787