Bosco Chiropractic

127 E. Park Ave., Libertyville, IL 60048
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boscochiropractic.com

Confidential Health Information—Child

Please allow our staff to photocopy your insurance card and drivers license. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

ABOUT THE CHILD

Name	Birthdate		
Address	City	State	Zip code
Phone #			
Age	Gender	Weight	

ABOUT THE PARENTS

Marital Status: M S W D

Name Parent 1	Phone #	Email Address
Relation	Employer	
Name Parent 2	Phone #	Email Address
Relation	Employer	

REASON FOR THIS VISIT

Describe the purpose this visit ______________________________

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Is the purpose of this appointment related to: ☐ Sports ☐ Auto ☐ Fall ☐ Home injury ☐ Other

Please explain: ______________________________

REASON FOR THIS VISIT CONTINUED

When did this condition begin? ______________________________

Has this condition: ☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with: ☐ Sleep ☐ Daily Routine ☐ Other activities

Please explain: ______________________________

Has this condition occurred before? ☐ Yes ☐ No

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name(s): ______________________________

Type of treatment: ______________________________

Results: ______________________________

MOTHER'S PREGNANCY AND LABOR

Any illness during your pregnancy: ______________________________

How was your delivery? ☐ Labor chemically induced ☐ Labor was Dr. assisted ☐ C-section delivery ☐ Forceps/vacuum extraction ☐ Did the Dr. pull or twist baby ☐ premature delivery

Please explain: ______________________________

Did you nurse the baby: ☐ Yes ☐ No
Did your baby have colic: ☐ Yes ☐ No
Feeding problems? ☐ Yes ☐ No
Vaccinations? ☐ Yes ☐ No

CHILD'S HEALTH HISTORY

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

- ☐ Allergies
- ☐ Frequent colds
- ☐ Asthma
- ☐ Headaches
- ☐ Attention problems
- ☐ Hyperactivity
- ☐ Bed wetting
- ☐ Irritability
- ☐ Breathing problems
- ☐ Skin problems
- ☐ Colic
- ☐ Sleeping disorders
- ☐ Constipation
- ☐ Tubes in the ears
- ☐ Digestive problems
- ☐ Vison problems
- ☐ Ear problems
- ☐ Other: ____________ ____________

CHILD'S CURRENT HEALTH STATUS

Has your child ever...	NO	YES	If Yes, please explain
Taken antibiotics?	☐	☐	
Been hospitalized?	☐	☐	
Had a severe fall?	☐	☐	
Been in a car accident?	☐	☐	

Is your child...

Accident prone?	☐	☐	________________
Had surgery?	☐	☐	________________
Currently taking any medication(s)?	☐	☐	________________

Is your child having difficulty interacting with others?

☐ Yes ☐ No If Yes, please explain: ____________________

Have you or anyone noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

☐ Yes ☐ No If Yes, please explain: ____________________

What changes (if any) in your child's health or behavior would you like accomplished?

____

____

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EXPERIENCE WITH CHIROPRACTIC CARE

Who referred you to this office? ____________________

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits? ____________________

Doctor's Name: ____________________ Approximate date of last visit: ____________________

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Dino G. Bosco and Dr. Amanda M. Beggi and whomever they may designate as their assistants to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctors deems appropriate.

Name of parent or guardian: ____________________

Signature of parent or guardian: ____________________ **Date:** ____________________