Children's Health Record

To be completed for all children under the age of 16

Child Information

Name: _____

Birthdate: _____

Nickname: _____

Gender: ❑ Male ❑ Female

Height _____ Weight: _____

Parent/Guardian's Information:

Name: _____

Address: _____

City/St/Zip: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Payment Information:

Method: ❑ Cash ❑ Check ❑ Credit Card

Credit Acct # _____ exp ___

Health Insurance Comp_____

Policy Number _____

Policy Holder Name: _____

Policy Holder Social Security #_____

Purpose for visit

Describe the reason for this visit:

_____

_____

How long has your child experienced this problem?

_____

Was this problem the result of
Has it gotten better or worse over time?
❑ Better ❑ Worse ❑ About the same ❑ comes and goes

Other health care professionals consulted for this problem
Name: _____ Type: ___
Name: _____ Type: ___
Name: _____ Type: ___

Are you content with the overall health of your child? ❑ Yes ❑ No

Health History

Has the child ever had any of the following problems?

❑ Ear infections
❑ Vision impairment
❑ Hearing impairment
❑ Sleeping problems
❑ Frequent colds
❑ Hyperactivity
❑ Attention problems
❑ Ear Infections
❑ Constipation
❑ Neck Pains
❑ Digestive Problems
❑ Recurring Fevers
❑ Eczema / Skin Problems
❑ Bronchitis / Upper Respiratory Infections
❑ Colic
❑ Back Pains
❑ Headaches
❑ Allergies
❑ Asthma
❑ Scoliosis
❑ Seizures
❑ Chronic Colds
❑ Diarrhea
❑ Headaches
❑ Sinus Troubles
❑ Bed Wetting
❑ Growing Pain

❑ Other _____

_____

_____

Is your child currently taking any medication?
❑ Yes ❑ No
If "yes" please list medications and reason:

_____

Has your child ever taken antibiotics? ❑ Yes ❑ No
If "yes" please explain:

_____

Check the vaccinations the child has received:
❑ DPT
❑ MMR
❑ Polio
❑ Measles
❑ Chicken Pos
❑ Hepatitis
❑ Other: _____

Pre-natal / Mother's Health History

During pregnancy, did the child's mother:

Take any medication	❑ Yes	❑ No
If yes, explain:		
Smoke	❑ Yes	❑ No
Consume alcohol	❑ Yes	❑ No
Experience any illness	❑ Yes	❑ No
Was labor chemically induced?	❑ Yes	❑ No
Was labor doctor-assisted?	❑ Yes	❑ No
Was a C-Section performed?	❑ Yes	❑ No
Were forceps or vacuum extraction used?	❑ Yes	❑ No
Was the delivery premature?	❑ Yes	❑ No

AUTHORIZATION FOR CARE OF MINOR

I / We, the undersigned parent(s) and/or guardian(s) of

_____ SS#: _____-____-_____, a

minor, do hereby authorize this office and its doctors to administer chiropractic care to my child, as they deem necessary.

_____
Parent or legal guardian's name (please print)

_____
Parent or legal guardian's signature

_____
Witness's signature

_____
Date

Agreement for Payment of Services

By signing the authorization above I affirm that I understand and agree that:

- health and accident insurance policies are an arrangement between patients and their insurance carriers;
- this office will prepare any necessary reports and forms to assist me in making collection from the insurance company;
- any amount that is authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account;
- all services rendered to me are charged directly to me and that I am personally responsible for the payment of my account; and
- it is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made.