FAMILY CHIROPRACTIC ASSOCIATES

Child Patient Health Record

Child's Name (First & Last): ________________________________ Preferred Name/Nickname: ______________________
Address: ____________________________________ City: ___________________ State: _______ Zip Code: __________
Date of Birth: _________________ Age: ____ Gender: _____________ Social Security #: _____________________________
Pediatrician: ____

Parent's Name: _______________________________ Cell Phone: _________________ Home Phone: __________________
Parent's Email: ____ Marital Status: _________________
Occupation: ____ Employer: ______________________________________
Work Address: ____ Work Phone: ____________________________
Social Security #: _______________________________ Who referred you to this office? _____________________________

Reason for this visit

Describe the purpose of this visit: ____
____
When did this condition begin? ____
Has this condition:

☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:

☐ Sleep ☐ Daily routine ☐ Sports
☐ Behavior ☐ Other (explain) ___________________

Has this condition occurred before? ☐ No ☐ Yes (explain) ____________________________________

Have you seen other providers for this condition?

☐ No ☐ Yes (Providerr's name, type of treatment & results): _____________________________________
____

Child's experience with Chiropractic

Has your child been adjusted by a chiropractor before? ☐ No ☐ Yes (Doctor's Name): ____________________________
If yes, reason for those visits: ____ Approx. date of last visit: __________
Has any adult in your family seen a chiropractor? ☐ No ☐ Yes

Mother's Pregnancy, Labor/Delivery & Post-Partum

During Pregnancy, did the mother:
Take medications (type):____
Consume tobacco / alcohol / drugs (type):____
Experience any illnesses? (type)____

Regarding labor/delivery, please check any of the following that apply:

☐ Labor was chemically induced ☐ Forceps/Vacuum extraction ☐ Premature delivery ☐ C-section delivery

Did the person assisting the delivery twist or pull the baby during delivery? ☐ Yes ☐ No

Was your child breast-fed? ☐ Yes ☐ No
Did your child experience
any feeding problems? ☐ Yes ☐ No

Child's Health History

Please check each of the conditions or diseases that you are experiencing now or have had in the past. While these may seem unrelated to the purpose of the appointment, they can affect the overall analysis, care plan and the possibility of being a candidate for care.

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

Please check any vaccinations that your child has received:

☐ DPT ☐ MMR ☐ Chicken Pox ☐ Hepatitis ☐ Other: ______________________

Describe any and all reactions to vaccines: ____

Child's current health status

Has your child ever:

Taken antibiotics? ☐ No ☐ Yes (explain) ____

Been hospitalized? ☐ No ☐ Yes (explain) ____

Had a severe fall? ☐ No ☐ Yes (explain) ____

Been in a car accident? ☐ No ☐ Yes (explain) ____

Had surgery? ☐ No ☐ Yes (explain) ____

Is your child:

Accident prone? ☐ No ☐ Yes (explain) ____

Taking any medication(s)? ☐ No ☐ Yes (explain) ____

Goals for my child's care

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

____

Would you like help with:

Improving posture ☐ Yes ☐ No

Exercise ☐ Yes ☐ No

Nutrition ☐ Yes ☐ No

Meditation ☐ Yes ☐ No

Stress reduction ☐ Yes ☐ No

Weight loss ☐ Yes ☐ No

Flexibility ☐ Yes ☐ No

Reducing current medications ☐ Yes ☐ No

Additional health goals or comments:

____

____

____

____

____

____

____

____

I hereby authorize the providers at Family Chiropractic Associates to examine and/or provide chiropractic care for my child.

____
Parent or Legal Guardian Name (Print)

____
Child / Patient's Name

____
Parent or Legal Guardian's Signature

____
Date