

# CHILDREN'S HEALTH RECORD

## ABOUT THE CHILD

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender  M  F  
Height \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Parent's Name \_\_\_\_\_  
Parent's Employer \_\_\_\_\_  
Parent's Work Phone \_\_\_\_\_  
Health Insurance Co. \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_  
Policy Holder's Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MOTHER'S PREGNANCY & LABOR

During Pregnancy, did the mother:  
... take any medication?  No  Yes

Explain \_\_\_\_\_

...smoke or consume alcohol?  No  Yes  
...experience any illness?  No  Yes

Explain \_\_\_\_\_

Approximately how long did labor last? \_\_\_\_\_ hours

Was labor chemically induced?  No  Yes  
Was labor doctor assisted?  No  Yes  
Was a C-section performed?  No  Yes  
Were forceps or vacuum extraction used?  No  Yes  
Did the delivery doctor pull or twist the  
baby during delivery?  No  Yes  
Was the delivery premature?  No  Yes

If "Yes", at \_\_\_\_\_ month and \_\_\_\_\_ weight

Check any of the following if the child experienced it immediately  
after birth.

- Jaundice  Respiratory Problems  
 Feeding Problems  Displaced or Broken Joints  
 Other condition(s) \_\_\_\_\_

## REASON FOR THIS VISIT

Describe the purpose for this visit. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the purpose of this appointment related to:

- Sports  Auto  Fall  Home Injury

- Chronic Discomfort  Other \_\_\_\_\_  
\_\_\_\_\_

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

Explain \_\_\_\_\_

Has this condition occurred before?  No  Yes

Explain \_\_\_\_\_

Have you seen others for this condition?  No  Yes

Who? \_\_\_\_\_

Treatment? \_\_\_\_\_

Results? \_\_\_\_\_

## CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has  
no or has had in the past. While they may seem unrelated to the  
purpose of the appointment, they can affect the overall diagnosis.

- |   |   |
|---|---|
| <input type="checkbox"/> Vision Problems    | <input type="checkbox"/> Pink Eye           |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Ear Problems       |
| <input type="checkbox"/> Sleeping Disorders | <input type="checkbox"/> Tubes in the Ears  |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Skin Problems      | <input type="checkbox"/> Frequent Colds     |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Colic              |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Hyperactivity      | _____                                       |
| <input type="checkbox"/> Constipation       | _____                                       |
| <input type="checkbox"/> Bed Wetting        |   |

## CHILD'S CURRENT HEALTH STATUS

- Is your child accident prone?  No  Yes
- Has your child:
- ...been hospitalized?  No  Yes
- ...had a sever fall?  No  Yes
- Has your child ever taken antibiotics?  No  Yes

If "Yes", explain \_\_\_\_\_

- Is your child currently taking any medication?  No  Yes

If "Yes", explain \_\_\_\_\_

Does your child have difficulty interacting with schoolmates or friends?  No  Yes

Gave you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?  No  Yes

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

## VACCINATIONS

- Have you chosen to vaccinate your child?  No  Yes

If "Yes", check all that apply

- DPT  MMR  Polio  Chick Pox
- Hepatitis  Other \_\_\_\_\_

Describe any and all reactions to vaccine(s). \_\_\_\_\_

## GOALS FOR MY CHILD'S CARE

Children see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh you needs and desires when recommending your child's chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care**- Symptomatic relief of pain or discomfort
- Corrective Care**- Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care**- Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.
- I want the doctor to select the type of care appropriate for my child.

\_\_\_\_\_  
Parent/Guardian's signature

\_\_\_\_\_  
Date

## AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the doctors of In Motion Chiropractic and whomever they may designate as their assistants to administer chiropractic care, to work with my child (name) \_\_\_\_\_ through the use of adjustments and procedures to the spine, as the doctor deems appropriate.

Insurance:

I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

Non-insurance:

I clearly understand and agree that all services rendered 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. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Parent of Legal Guardian's Name (print)

\_\_\_\_\_  
Parent or Guardian's signature Authorizing Care

\_\_\_\_\_  
Date (M/D/Y)

\_\_\_\_\_  
Witness's Signature

Who Should receive payment on this Account?

- Parent
- Personal Health Insurance
- Auto Insurance
- Medicare