# Children's Health Record

**ABOUT THE CHILD**

Name_____

Age_____ Date of Birth _____ Gender □ M □ F

Height_____ Weight _____

Parent's Name _____

Phone Number _____

Address_____

City/State/Zip_____

Health Insurance Co. _____ ID#_____

Policy Holder's Name & DOB _____

**MOTHER'S PREGNANCY & LABOR**

During Pregnancy, did the mother:

… take any medication? □ No □ Yes: Explain_____

…experience any illness? □ No □ Yes: Explain_____

…smoke or consume alcohol? □ No □ Yes

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

Explain_____

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 now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis.

| | | | |
|---|---|---|---|
| □ Vision Problems | □ Pink Eye | □ Headaches | □ Ear Problems |
| □ Sleeping Disorders | □ Tubes in the Ear | □ Irritability | □ Attention Problems |
| □ Skin Problems | □ Frequent Cold | □ Allergies | □ Colic |
| □ Breathing Problems | □ Asthma | □Hyperactivity | □ Digestive Problems |
| □ Constipation | □ Bed Wetting | | |

**CHILD'S CURRENT HEALTH STATUS**

Is your child accident prone? □ No □ Yes

Has your child:

…been hospitalized? □ No □ Yes

…had a severe 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

Have 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 □ Chicken 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 your 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 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