DELAFIELD CHIROPRACTIC

CHILD HEALTH RECORD

ABOUT THE CHILD

Name_____

Address_____

City_____St_____ZIP_____

Home phone_____

Birth Date_____

SS#_____

Age_____Gender M / F Weight_____

ABOUT THE PARENT

Name (mother)_____

Name (father)_____

Alternate phone (mother)_____

Alternate phone (father)_____

E-mail address_____

ANY SIBLINGS

Name_____Age_____

Name_____Age_____

Name_____Age_____

Name_____Age_____

REASON FOR THIS VISIT

Describe the purpose of this visit_____

_____

Is the purpose of this appointment related to

Wellness Sports Auto Fall Home Injury

Please 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

Please explain_____

_____

Has this condition occurred before? **Yes No**

Please explain_____

Have you seen other doctors for this? **Yes No**

Doctor's Name_____

Type of treatment_____

_____

Results_____

_____

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

◇ Drugs / Medicine ◇ Tobacco / Alcohol

Please explain_____

Any illness during your pregnancy_____

_____

How was your delivery?_____

◇ Labor chemically induced ◇ Labor was Dr. assisted

◇ C-section delivery ◇ Forceps/Vacuum extrac

◇ Did Dr. pull or twist baby? ◇ Premature delivery

◇ Breech ◇ Jaundice(yellowish)

◇ Cyanotic(blue)

Please explain:_____

_____

Did you nurse the baby? **Yes No**

Did your baby have colic? **Yes No**

Feeding problems? **Yes No**

APGAR Score if Known:_____

Describe birthmarks if any_____

_____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

*Doctors of Chiropractic work with the nervous system? **Yes No**

*The nervous system controls all bodily functions and systems? **Yes No**

*Chiropractic is the largest natural healing profession in the world? **Yes No**

*If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? **Yes No**

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, care plan and the possibility of being accepted 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 ears
○ Vision problems
○ Other

VACCINATIONS

Have you chosen to vaccinate your child? **Yes No**

If yes, circle all that your child has received.

DPT MMR Chicken Pox Hepatitis Other

Describe any and all reactions to vaccine(s)._____

_____

EXPERIENCE WITH CHIROPRACTIC

Who referred you?_____

Have you been adjusted by a Chiropractor before **Y N**

Reason for those visits?_____

Doctor's name_____

Approximate date of last visit?_____

Has any adult in your family seen a Chiropractor? **Y N**

Has any child in your family seen a Chiropractor? **Y N**

FAMILY HISTORY

Please mark the following conditions as they pertain to your family: (i.e. mother, father, brother,sister,grandparent)

	YES	NO	who?		YES	NO	who?
Cancer	Yes	No	_____	Diabetes	Yes	No	_____
Heart problems	Yes	No	_____	Epilepsy	Yes	No	_____
Kidney problems	Yes	No	_____	Allergies	Yes	No	_____

CHILD'S CURRENT HEALTH STATUS

	YES	NO	If yes, please explain
Has your child ever:			
…..taken antibiotics?	**Y**	**N**	_____
…..been hospitalized?	**Y**	**N**	_____
…..had a severe fall?	**Y**	**N**	_____
…..been in a car accident?	**Y**	**N**	_____
Is your child			
…..accident prone?	**Y**	**N**	_____
Had Surgery? Please explain…	**Y**	**N**	_____
…..currently taking any medication(s)?	**Y**	**N**	_____
…..having difficulty interacting with others?	**Y**	**N**	_____

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

_____

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

_____

AUTHORIZATIONS

I understand and agree to the following:

1) A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services.
2) It is my responsibility to complete the clinic's forms accurately and to notify the doctor if any of my information has changed or requires updating.
3) If any x-rays are taken they will remain the property of Delafield Chiropractic and may be checked out on a per need basis, but need to be returned to our clinic as soon as possible or within 60 days. The payments to the doctor for x-rays is for examinations of x-rays only.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Michelle A. Riegleman to administer chiropractic care, to work with my condition through the use of adjustments and procedures that the doctor deems appropriate. I clearly understand and agree that all services rendered me 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 Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I hereby authorize assignment of my insurance rights and benefits (If applicable to the provider for services rendered.

Name of parent or guardian:_____Date:_____