Child Member Health Record

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: ❑ SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):

❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?

❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

❑ WELLNESS ❑ CONDITION

IF CONDITION, DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER

PLEASE EXPLAIN:

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:

❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

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/CHIROPRACTORS FOR THIS CONDITION?

❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

St. Croix Chiropractic
446 S. Knowles Ave.
New Richmond, WI 54017

COMPLETE THIS PAGE FOR CHILDREN 4-8 YEARS OF AGE ***Date_____***

CHILD'S CURRENT HEALTH

DURING PREGNANCY DID YOU USE:

❑ DRUGS/MEDICATIONS ❑ TOBACCO/ALCOHOL

IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR DELIVERY:

❑ LABOR WAS CHEMICALLY INDUCED ❑ LABOR WAS DOCTOR ASSISTED
❑ C-SECTION DELIVERY ❑ FORCEPS/VACUUM EXTRACTION
❑ DOCTOR PULLED OR TWISTED BABY ❑ PREMATURE DELIVERY

PLEASE EXPLAIN:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ❑ YES ❑ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

❑ YES ❑ NO

PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT?

❑ YES ❑ NO

PLEASE EXPLAIN:

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)

❑ YES ❑ NO

PLEASE LIST:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child 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.*

❑ ASTHMA	❑ EAR INFECTIONS	❑ SORE THROAT
❑ BED WETTING	❑ HEADACHES	❑ UPSET STOMACH
❑ BRONCHITIS	❑ HYPERACTIVITY	❑ URINARY INFECTIONS
❑ CONSTIPATION	❑ LEARNING DISORDERS	
❑ DIARRHEA	❑ NERVOUSNESS	

NUTRITION

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET?

❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE FOOD ALLERGIES?

❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURING SKIN RASHES?

❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?

❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD ELIMINATE STOOLS EACH DAY?

❑ YES ❑ NO

PLEASE EXPLAIN: