CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Explain _____

Name			DEAGON EOD THIS MIST					
Home PhoneBirthdate								
Age	Gender 🖵 M	ūΕ		Describe the purpose of this visit.				
Height	Weight		_					
Address				Is the purpose of this				
City/State/Zip				□ sports □ auto □ fall □ home injury □ chronic discomfort □ other				
Parent's Name			_	Explain				
Parent's Employer				When did this condition	on begin?			
Parent's Work Phone				Has this condition				
Payment Method 🗅 Ca	ash 🗆 Check 🗅	Credit Card		gotten worse	a stayed con	stant 👊 comes and goes		
Crdt Cd. # exp				Does this condition interfere with				
				□ sleep □	a daily routin	e • other activities		
Health Insurance Co. NamePolicy Number				Evoluin				
Policy Holder's Name				Has this condition occurred before? ☐ Yes ☐ No — Fiveleip				
Policy Holder's Social Security #								
Tolloy Holder 5 coolar co				Have you seen other	doctors for th	nis condition? 🗅 Yes 🗅 No		
				_				
MOTHER'S PR	EGNANCY & LA	BOR						
During pregnancy, did thetake any medication?		□ Yes						
Explain								
smoke or consume al	cohol? • No	□ Yes		CHILD'S	HEALTH	HISTORY		
experience any illness		☐ Yes	Dloo	na chook asch of the d	licaneae ar co	anditions that the child has		
Explain			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					
Approximately how long	did labor last?	hours				affect the overall diagnosis		
Was labor chemically ind		□ Yes						
Was labor doctor assisted Was a C-Section perform		□ Yes □ Yes		Vision Problems		Pink Eye		
Was a 0-Section perform Were forceps or vacuum		☐ Yes		Headaches		Ear Problems		
Did the delivery doctor pu		_ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Sleeping Disorders		Tubes in the Ears Attention Problems		
baby during delivery?		☐ Yes		Irritability Skin Problems		Frequent Colds		
Was the delivery prematu	ire? 🗅 No	Yes		Allergies		Colic		
If "Yes", at	month and	weight		Breathing Problems		Digestive Problems		
Check any of the following if the child experienced it immediately after birth.				☐ Asthma ☐ Other				
☐ Jaundice ☐ Respiratory Problems		ns		Hyperactivity Constipation	_			
☐ Feeding Problems ☐ Displaced or Broken Joints			Bed Wetting					
Other Condition(s)				_ Jug				

CHILD'S CURRENT HEALTH STATUS

ls your child accident prone?	ש No	∵ Yes		GOALS FOR MY CHILD'S CARE				
Has your child:			Chi	ldran eag Chironractors for a vari	aty of reasons. Some			
been hospitalized?		` ∟ Yes		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				
had a severe fall?		'⊐ Yes ⊐ Yes						
been in a car accident?								
Has your child ever taken antibiotics? If "Yes", explain		∟ Yes		en recommending your child's Ch				
Is your child <u>currently</u> taking any medication?	Yes		program. Please check the type of care desired so that we may be guided by your wishes whenever possible.					
If "Yes, explain				Relief Care — Symptomatic rel	ief of pain or			
Does your child have difficulty interacting with s	ites or		discomfort					
friends?	∟ No ∟ Yes			Gerrective Care — Correcting and relieving the cause of the problem as well as the symptoms				
Have you or anyone else noticed that your child	is nervo	us.	×49		•			
twitches, shakes or exhibits reaking behavior?		∟ Yes	i	Comprehensive Care — Bring whatever is entranchmong in the hody to the highest state of				
What changes (if any) in your calld's sealth or t	ehavior	would yo	ŭ.	- Casta possible a In Oteropr <mark>aci</mark> l				
like accomplished?	18 97 7 104 7 10		. (1	, spart the Doutonic select the tree, a shall	ype of care appropriate			
				Parent/Guardian's Signature				
	\	/ACC	INATION	5				
Have you chosen to vaccinate your child? DPT J MMR J Polio Describe any and all reactions to vaccine(Chick	ken Pox	→ Hepatitis	Other				
AUTHORIZA1	ΓΙΟΝ	TO C	ARE FOR	R A MINOR CHILD				
					d and a final a			
I hereby authorize the Doctors in this Chiroprac Chiropractic care, to work with my child (name the spine, as the Doctor deems appropriate.								
I clearly understand and agree that all services I agree that I am responsible for all bills incurred diagnosed conditions nor for any medical diagnorprofessional services rendered will become	ed at this nosis. Ta	office. T also unde	The Doctor will r erstand that if m	not be held responsible for any pr	e-existing medically			
I understand and agree that health and accider holder. I understand that the Doctor's Office winsurance company and that any amount authoreceipt. I hereby authorize assignment of insuring child.	vill prepai orized to	re any ne be paid d	cessary reports lirectly to the Do	and forms to assist me in collect octor's Office will be credited to m	ing from the y account on			
Patient's Name (Print)				Parent or Legal Guardian's Name (Print)				
Parent/Guardian's Signature Authorizing Care		Date (M/	(D/Y)	Witness' Signature				
Who should receive bills for payment on this	s accour	ıt?						
□ Parent □ Personal Health	Insuran	ce	Auto Insura د	ance J Medicare	→ Medicaid			