



Children's Health Record

About the Child:

Name: _____ Home Phone: _____

Birth date: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent's Name: _____ Parent's Employer: _____

Parent's Work Phone #: _____

Reason for this visit:

Describe the purpose of 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

Has this condition occurred before? Yes No Explain: _____

Have you ever seen other doctor's for this condition? Yes No

Dr.'s Name: _____

Type of Treatment: _____

Results: _____

Mother's Pregnancy and Labor

During Pregnancy did the mother:

...take any medication? Yes No Explain: _____

...smoke or consume alcohol? Yes No Explain: _____

...experience any illness? () Yes () No Explain: _____

Approximately how long did labor last? _____ Hours

Was labor chemically induced? () Yes () No Was labor doctor- assisted? () Yes () No

Was a c-section performed? () Yes () No Were forceps or vacuum used? () Yes () No

Did the doctor pull or twist the baby during delivery? () Yes () No

Was the delivery premature? () Yes () No If yes, at _____ month and _____ weight

Circle any of the following if the child experienced it immediately after birth:

Jaundice Feeding Problems Displaced or Broken Bones Other:

Child's Health History: Please circle each of the diseases or conditions that the child has had, now or in the past. While they may seem unrelated to the purpose of this visit, they can affect the overall diagnosis.

Vision Problems Pink Eye Headaches Ear Problems Sleeping Problems

Tubes in Ears Irritability Attention Problems Skin Problems Colic

Frequent Colds Allergies Breathing Problems Digestive Problems Asthma

Hyperactivity Constipation Bed Wetting Other: Explain _____

Child's Current Health Status:

Is your child accident prone? () Yes () No

Has your child ever been hospitalized? () Yes () No Had a severe fall? () Yes () No

Been in a car accident? () Yes () No

Has your child ever taken antibiotics? () Yes () No If yes, explain: _____

Is your child currently taking any medication? () Yes () No If yes, explain: _____

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

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

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

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Goals for My Child's Care:

Children see a chiropractor 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 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

Vaccinations:

Have you chosen to vaccinate your child? Yes No If yes, check all the vaccinations your child has received. DPT MMR Polio Chicken Pox Hepatitis Other _____

Describe any and all reactions to vaccines _____

Authorization to care for a Minor Child

I hereby authorize the Doctors in this Chiropractic Office, 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.

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. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that Rozenhart Family Chiropractic will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Rozenhart Family Chiropractic will be credited to my account upon receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

Child's Name: _____

Parent/Legal Guardian's name: _____

Parent/Legal Guardian's signature: _____

Date: _____