Health History – Child Care

Child's Name: _____DOB:_____Date:_____

Address: _____City: _____State: _____ Zip: _____

Mother's Name : _____Phone: _____

Father's Name: _____Phone : _____

Name & Number of Emergency Contact:_____Relationship:_____

How did you hear about the office: _____

Purpose of visit:Wellness Check-up_____ Injury or Accident_____ Other: _____

_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most of the time the effects are gradual and begin very early in life. *Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.*

Pregnancy:

Were there any complications during pregnancy?

_____

Was mom on any medications, prescription or over-the-counter? Yes _____ No _____

If yes, explain:

_____

Was baby ever in the Breech position? Yes _____ No _____

How many ultrasounds were performed? _____

Birth and Delivery:

Where was baby born? Home _____ Hospital _____ Birthing Center _____ Other: _____

Was the delivery: Vaginal _____ C-Section _____ Were any devices used? Forceps _____ Vacuum _____

How long was the labor? _____ How long was the delivery? _____

Was an epidural administered? Yes _____ No _____

Was oxytocin/pitocin used? Yes _____ No _____

Infancy:

Was infant vaccinated? Yes _____ No _____

Was there any prolonged use of medicines or an inhaler? Yes_____ No _____ If yes, which?

_____

Did the infant suffer any traumas such as a serious falls or car accidents? Yes _____ No _____

Childhood Years:

Did the child have any childhood illnesses? _____

Has the child had any surgeries? _____

Has the child been involved in any car accidents?_____

Does the child play in any youth sports?_____

Has your child suffered from: Please check (✓) all that apply.

____Headaches	____ Frequent Colds/Flu	____Neck Problems
____ Dizziness	____ADD/ADHD	____Low Back Problems
____ Fainting	____ Behavioral Problems	____ Scoliosis
____ Seizures	____ Learning Disorder	____ Arm or Leg Problem
____ Chronic Ear Aches	____ Colic	____ Posture
____ Asthma	____ Digestive Problems	____ Joint Pain
____ Allergies	____ Sleeping Problems	_____ Autism

I consent to a professional and complete chiropractic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. I authorize chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care on the behalf of.

I acknowledge that I understand the Office Policies & Procedures and that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

Appointment Cancellation Policy: To enhance appointment availability, anytime you are unable to keep your appointment, we ask that you notify us in advance. If prior notification is not given, you will be charged a $15 cancellation fee.

Parent/Guardian Signature: _____ Date: _____