Child Health Record 1

ABOUT THE CHILD

Name _____

Address _____

City _____

State | Zip Code _____ | _____

Home Phone _____ Gender ☐ M ☐ F

DOB _____ / _____ / _____ Age _____ yrs _____ mos

Social Security Number _____-_____-_____

ABOUT THE PARENTS

Parents Names _____

Address _____

☐ same as above

City _____

State | Zip Code _____ | _____

Mom's: Dad's:

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

E-mail _____

Would you like to receive our monthly newsletter? ☐ Yes ☐ No

CHIROPRACTIC EXPERIENCE

Who referred you to our office? _____

Have you seen or heard of our office because of (check all that apply):

☐ Onida Watchman ☐ Potter County News ☐ sign ☐ yellow pages ☐ website

Have you been adjusted by a chiropractor before? ☐ Yes ☐ No

If yes, then what was the reason for those visits?

_____

Approximate Date of Last Visit _____

Has anyone in your family ever seen a chiropractor? ☐ Yes ☐ No

REASON FOR THIS VISIT

Describe the reason for this visit: _____

_____

_____

_____

_____

Is the purpose of this appointment related to:

☐ sports ☐ auto ☐ fall ☐ home injury ☐ work 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 for this condition? ☐ Yes ☐ No

Doctor's name _____

Type of treatment: _____

Results:

_____

_____

_____

VACCINATIONS

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

Is your child on the recommended schedule? ☐ Yes ☐ No

Describe any and all reactions to vaccine(s):

_____

_____

Would you like to discuss vaccinations with Dr. Jess? ☐ Yes ☐ No

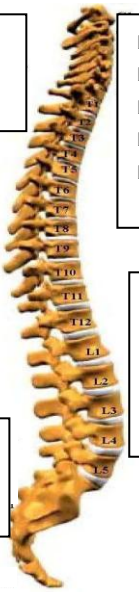
CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child currently or previously has had. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

- ☐ attention problems
- ☐ frequent colds
- ☐ vision problems

- ☐ ear problems
- ☐ sinus problems
- ☐ colic
- ☐ sleeping disorders
- ☐ headaches

- ☐ asthma
- ☐ food allergies
- ☐ environmental allergies
- ☐ drug allergies
- ☐ other allergies
- ☐ hyperactivity



- ☐ bed wetting
- ☐ constipation
- ☐ skin problems
- ☐ breathing problems
- ☐ digestive problems

- ☐ hay fever
- ☐ acne
- ☐ reflux/heartburn
- ☐ irritability

Other(s):

_____

_____

_____

_____

CHILD'S HEALTH STATUS

Has your child ever:

been hospitalized? ☐ Yes ☐ No

had a severe fall? ☐ Yes ☐ No

been in a car accident? ☐ Yes ☐ No

had surgery? ☐ Yes ☐ No

displayed twitches, shakes, or rocking behavior? ☐ Yes ☐ No

CHILD'S MEDICATIONS/SUPPLEMENTS/VITAMINS

Your child currently takes: _____

_____

_____

ALLERGY CONCERNS

Do you have allergies? Or do you think you may have allergies? Have you tried everything? Don't give up.

N.A.E.T. (Nambudripad's Allergy Elimination Technique) offers hope!

N.A.E.T. is a synthesis of various medical disciplines such as allopathy, acupuncture, chiropractic, kinesiology, and nutrition.

Dr. Jess is a certified N.A.E.T. practitioner.

Would you like more information? ☐ Yes ☐ No

MOTHER'S PREGNANCY & LABOR

During pregnancy, did you use:

☐ drugs/medications ☐ tobacco ☐ alcohol ☐ prenatal vitamins

While pregnant, did you experience any:

illness(es)?	☐ Yes ☐ No	falls?	☐ Yes ☐ No
MVAs?	☐ Yes ☐ No	high BP?	☐ Yes ☐ No
diabetes?	☐ Yes ☐ No	morning sickness?	☐ Yes ☐ No
indigestion?	☐ Yes ☐ No	back pain?	☐ Yes ☐ No
abnormal bleeding?	☐ Yes ☐ No	swollen ankles?	☐ Yes ☐ No

Did you receive chiropractic care while pregnant? ☐ Yes ☐ No

Did you receive massage therapy while pregnant? ☐ Yes ☐ No

What was the term of your pregnancy? _____ weeks

How many children do you have? _____

How long was the 2nd stage (the pushing phase) of labor? _____ hours

Describe your delivery:

- ☐ labor was chemically induced
- ☐ c-section delivery (planned or emergency)
- ☐ vaginal delivery
- ☐ fetal distress occurred
- ☐ doctor pulled or twisted baby
- ☐ forceps/vacuum extraction

Baby's presentation was ☐ head (normal) ☐ face ☐ breech.

Did you nurse baby? ☐ Yes ☐ No How long? _____ mos

Did baby have a 1-sided breast feeding preference? ☐ Yes ☐ No _____

Did baby have a preferred head position? ☐ Yes ☐ No _____

CHIROPRACTIC AWARENESS

Doctors of chiropractic work with the nervous system? ☐ Yes ☐ No

The nervous system controls all bodily functions & systems? ☐ Yes ☐ No

If chiropractic care starts at birth, then you can achieve a higher level of health throughout life? ☐ Yes ☐ No

Child's Name _____

Parent or Guardian Authorizing Care Signature _____ **Date** _____