Child Member Health Record

ABOUT THE CHILD

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE: | GENDER:

HEIGHT: | WEIGHT:

SIBLINGS NAMES AND AGES:

GENERAL HISTORY

DOES YOUR CHILD EAT WELL ❑ YES ❑ NO

ARE YOU AWARE OF THE IMPACT NUTRITION CAN HAVE ON YOUR CHILD'S BEHAVIOR? ❑ YES ❑ NO

WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION FOR YOUR CHILD?
❑ YES ❑ NO

DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS ❑ YES ❑ NO

DOES YOUR CHILD SLEEP WELL ❑ YES ❑ NO

DOES YOUR CHILD SLEEP ON HIS/HER ❑ SIDE ❑ STOMACH ❑ BACK

PLEASE DESCRIBE HIS/HER SLEEPING HABITS:

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:
❑ DPT ❑ MMR ❑ CHICKEN POX ❑ HEPATITIS ❑ OTHER

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

LIST PRESCRIPTION MEDICATION/SUPPLEMENTS TAKEN:

LIST ANY ALLERGIES YOUR CHILD HAS :

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:

ADDRESS:
❑ SAME AS ABOVE

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

WORK PHONE: | POSITION TITLE:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAS YOUR CHILD EVER BEEN CHECKED BY A CHIROPRACTOR?
❑ YES ❑ NO ❑ DON'T KNOW

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

CHIROPRACTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ❑ CONDITION ❑ WELLNESS
IF CONDITION, PLEASE DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER

DID THIS CONDITION START:
❑ SUDDENLY ❑ GRADUALLY ❑ POST INJURY

WHAT DATE DID THIS CONDITION START?

IS THIS PROBLEM: ❑ OCCASIONAL ❑ FREQUENT ❑ CONSTANT

WHAT MAKES THIS PROBLEM BETTER?

WHAT MAKES THIS PROBLEM WORSE?

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ SLEEP ❑ DAILY ROUTINE ❑ EATING ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT/TESTING:

RESULTS:

Well Within Chiropractic
2500 E. Enterprise Ave Suite E
Appleton, WI 54913

COMPLETE THIS PAGE FOR CHILDREN 4 to 8 YEARS OF AGE

BIRTH HISTORY

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? ❑ YES ❑ NO

DID YOU SUFFER ANY TRAUMAS, FALLS, OR ACCIDENTS? ❑ YES ❑ NO

PLEASE EXPLAIN:

DURING PREGNANCY DID YOU USE: ❑MEDICATIONS
❑ TOBACCO/ALCOHOL ❑ SUPPLEMENTS

IF YES, PLEASE LIST:

ULTRASOUND DURING PREGNANCY? ❑ YES ❑ NO NUMBER: _____

MEDICAL REASON FOR ULTRASOUND?

LOCATION OF BIRTH: ❑ HOME ❑ BIRTHING CENTER ❑ HOSPITAL

WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? _____ WEEKS

DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY:

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

PLEASE EXPLAIN:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT:

BIRTH LENGTH:

WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY ❑ YES ❑ NO

DID YOU BREASTFEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION? ❑ YES ❑ NO

DID YOU FORMULA FEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA?

❑BRUISNG
❑RESPIRATORY DISTRESS
❑FAST OR EXCESSIVELY LONG BIRTH
❑ODD SHAPED HEAD
❑ STUCK IN THE BIRTH CANAL
❑CORD AROUND NECK
❑LACK OF USE OF ONE ARM
❑ HEAD ROTATED TO ONE SIDE

GROWTH &DEVELOPMENT

DOES YOUR CHILD HAVE ANY DEVELOPMENTAL OR DEVELOPMOTOR DELAYS? ❑ YES ❑ NO

IF YES, PLEASE DESCRIBE AND INCLUDE INTERVENTIONS:

HOW MANY TIMES/WEEK DOES YOUR CHILD EAT FAST FOOD? _____

CANDY/COOKIES?_____ SODAS?_____

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

❑ YES ❑ NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?

HOW MANY TIMES?:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO

PLEASE EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).

WAS THIS THE CASE FOR YOUR CHILD? ❑ 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

AT WHAT AGE DID YOUR CHILD START DAYCARE? _____

❑ IN-HOME ❑ DAYCARE CENTER

DOES YOUR CHILD ATTEND SCHOOL/PRESCHOOL? ❑ YES ❑ NO

DOES YOUR CHILD CARRY A BACKPACK? ❑ YES ❑ NO

WHAT IS THE APPROXIMATE WEIGHT?_____

AVERAGE NUMBER OF HRS OF TV/VIDEO GAMES PER WEEK ?_____

ARE THERE ANY SMOKERS LIVING IN THE HOME? ❑ YES ❑ NO

ARE THERE ANY INDOOR PETS IN YOUR HOME? ❑ YES ❑ NO

DO YOU USE GREEN CLEANING PRODUCTS IN YOUR HOME? ❑ YES ❑ NO

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CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ YES ❑ NO

SYSTEMS REVIEW

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS/SYMPTOMS YOUR CHILD HAS EXPERIENCED:

❑ ACID REFLUX
❑ BED WETTING
❑ CONSTIPATION
❑ EAR INFECTIONS
❑ DIARRHEA
❑ COLIC
❑ ASTHMA
❑ POOR COORDINATION
❑ BRONCHITIS
❑ SLEEPING DIFFICULTIES
❑ NECK PAIN
❑ LOW BACK PAIN
❑ DIFFICULT WEIGHT GAIN
❑ LEARNING DISORDERS
❑ DIARRHEA
❑ FREQUENT COLDS/COUGHS/FLUS
❑ HYPERACTIVITY
❑ HEADACHES
❑ FEVERS
❑ SORE THROATS
❑ ALLERGIES
❑ URINARY PROBLEMS
❑ UPPER BACK PAIN
❑ SHORTNESS OF BREATH

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

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

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____ ❑ M ❑ F ❑ S ❑ G

DEPRESSION ❑ M ❑ F ❑ S ❑ G

DIABETES ❑ M ❑ F ❑ S ❑ G

HEART DISEASE ❑ M ❑ F ❑ S ❑ G

LIVER DISEASE ❑ M ❑ F ❑ S ❑ G

HIGH CHOLESTEROL ❑ M ❑ F ❑ S ❑ G

HIGH BLOOD PRESSURE ❑ M ❑ F ❑ S ❑ G

LUNG PROBLEMS ❑ M ❑ F ❑ S ❑ G

SEIZURES ❑ M ❑ F ❑ S ❑ G

NECK PROBLEMS ❑ M ❑ F ❑ S ❑ G

BACK PROBLEMS ❑ M ❑ F ❑ S ❑ G

SCOLIOSIS ❑ M ❑ F ❑ S ❑ G

OSTEOARTHRITIS ❑ M ❑ F ❑ S ❑ G

RHEUMATOID ARTHRITIS ❑ M ❑ F ❑ S ❑ G

AUTOIMMUNE DISEASES ❑ M ❑ F ❑ S ❑ G

OTHER:_____

AUTHORIZATION FOR CARE OF A MINOR

I _____, the ☐mother, ☐father, ☐legal guardian of _____ consent to the rendering of care, including diagnostic procedure, chiropractic adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me 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 if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

SIGNATURE:	DATE: