CHILD PATIENT HEALTH RECORD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home Ph# _____

Birth Date _____

SS# _____

Age _____ Gender _____ Weight _____

ABOUT THE PARENT

Name _____

Employer _____

Work address _____

Work Ph _____ Cell _____

E-mail address _____

SS# _____

Insurance Co. _____

Insured's name _____

Insured's SS# _____ DOB _____

VACCINATIONS

Have you chosen to vaccinate your child? Yes No

If yes, circle all that your child has received

DPT MMR Chicken Pox Hepatitis Other

Describe any and all reactions to vaccine(s): _____

_____

REASON FOR VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

Sports Auto Fall Home Injury Other

Please explain: _____

_____

When did this condition begin? _____

Has this condition:

Gotten worse Stayed constant Comes and goes

Please explain: _____

_____

Has this condition occurred before? Yes No

Please explain: _____

Have you seen other doctors for this condition? Yes No

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

*Doctors of chiropractic work with the nervous system?	Yes	No
*The nervous system controls all bodily functions and systems?	Yes	No
*Chiropractic is the largest natural healing profession in the world?	Yes	No
*If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	Yes	No

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? Yes No Has any child in your family seen a Chiropractor? Yes No

MOTHER'S PREGNANCY & LABOR

During pregnancy:

☐ Drugs/Medicine ☐ Tobacco/Alcohol

Please explain _____

Any illness during pregnancy? _____

_____

How was your delivery? _____

☐ Labor chemically induced
☐ C-Section delivery
☐ Did Dr pull or twist
☐ Labor was Dr. assisted
☐ Forceps/Vacuum extraction?
☐ Premature delivery

Did you nurse the baby? Yes No Did your baby have colic? Yes No
Feeding problems? Yes No Vaccinations? Yes No

CHILD'S HEALTH HISTORY

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 purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

☐ Allergies
☐ Asthma
☐ Attention Problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear Problems
☐ Frequent colds
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Skin problems
☐ Sleeping disorders
☐ Tubes in ears
☐ Vision problems
☐ Other: _____

CHILD'S CURRENT HEALTH STATUS

			If yes, please explain
Has your child ever:			
• Taken antibiotics	Yes	No	_____
• Been hospitalized	Yes	No	_____
• Had a severe fall	Yes	No	_____
• Been in a car accident	Yes	No	_____
Is your child:			
• Accident prone	Yes	No	_____
• Had surgery	Yes	No	_____
• Currently taking any medication(s)	Yes	No	_____
• Having difficulty interacting with others	Yes	No	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? _____

_____

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

_____

AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Mitchell Family Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATIONFOR CARE OF A MINOR
I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to 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 Dr. 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.

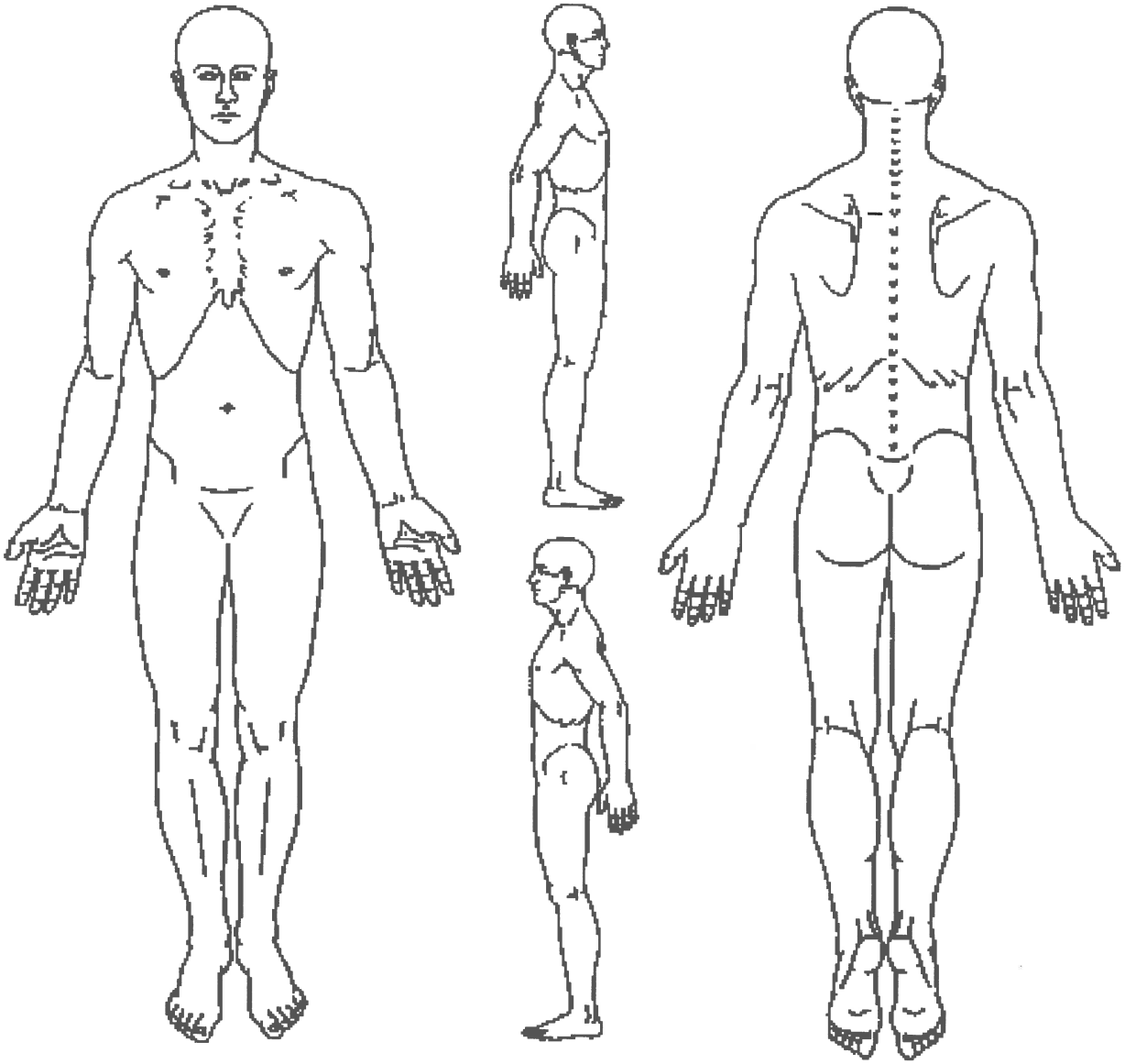
Signature of parent or guardian _____ Date _____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had pain/discomfort ____ years ____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain/discomfort, right now.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

Please Read: This questionnaire is designed to enable us to understand how much your pain/discomfort has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/2 mile.
D. I can only walk while using a cane or on crutches.
E. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from having a social life.

SECTION 9--Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.