Child's Health History

NAME _____ **DATE** _____

PARENTS/GUARDIANS _____

ADDRESS _____ **CITY/STATE** _____ **ZIP** _____

HOME PHONE _____ **PARENT WORK PHONE/S** _____

BIRTHDATE _____ **OTHER CHILDREN - NAMES/AGES** _____

_____

WHO REFERRED YOU TO US? _____

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION _____

_____ **LAST VISIT** _____

CURRENT MEDICAL CARE? YES/NO WHY? _____

CURRENT DRUGS/MEDICATION _____

REASON FOR CONSULTING THIS OFFICE _____

_____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR CHILD'S HEALTH/WELLBEING.

- ❑ **I am only concerned about relief of a particular symptom.**
- ❑ **I am only concerned about relief of a particular symptom, and preventing its return.**
- ❑ **I want optimum health and wellbeing on every level for my child.**

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

I understand and agree that:1) health insurance and accident insurance policies are an arrangement between an insurance carrier and myself; 2) this office will prepare any necessary reports and forms to assist me in making collections from my primary insurance company only and that any amount authorized to be paid directly to this office will be credited to my account on receipt; 3) all services rendered to me are charged to me and I am personally responsible for payment; 4) this office as a courtesy to me will not impose any interest charges to any balance I may incur for a period of thirty days after the charges are incurred, to afford my insurance carrier , if , any, that amount of the time to make the payment; 5) any balances outstanding for more than thirty days will be charged interest at the rate of 2% per month and I agree to pay reasonable attorney's fee and any expenses or cost relating to the collection proceedings, including court costs;7) in the event the patient is a minor , I am the parent and/ or guardian of said patient and agree that I am responsible for all services rendered to the patient.

Signature _____ **Date** _____

- ❖ The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.
- ❖ This interference is most commonly the result of vertebral subluxations.
- ❖ Physical, chemical or emotional stress may cause these subluxations.
- ❖ The practice of chiropractic is based on the location and reduction of nerve system interference caused by vertebral subluxations.

Please check any that apply

- ❑ Any illness during pregnancy?
- ❑ Drugs/medicine/tobacco/alcohol in pregnancy
- ❑ Labor chemically induced?
- ❑ Pulling or twisting during delivery?
- ❑ Forceps/Vacuum Extraction/C-section?
- ❑ Premature delivery?
- ❑ Vaccinations?
- ❑ Jaundice treatment?
- ❑ Colic?
- ❑ Eating or nursing problems?
- ❑ Sleeping problems?
- ❑ Falls in first year of life?
- ❑ Other falls or injuries?
- ❑ Respiratory problems?
- ❑ Ear infections?
- ❑ Allergies/Asthma?
- ❑ Digestive problems?
- ❑ Hyperactivity?
- ❑ Poor Nutrition?
- ❑ Auto Accident or Injury?
- ❑ Sports Injury?
- ❑ Family/Home Stress?
- ❑ Prescription Drug Use?
- ❑ Non-Prescription Drug Use?
- ❑ Ever Hospitalized?
- ❑ Surgery?
- ❑ Any Major Illness?
- ❑ Reoccurring Illnesses?
- ❑ Limited Exercise?
- ❑ Any other health related problems?

Explain: _____

Anything else? _____

I hereby authorize Dr. _____ and whoever may be designated as assistants to provide chiropractic care as may be deemed necessary to my child/ward: _____

Signed: _____