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CHILDREN'S HEALTH PROFILE

Please answer all questions as completely as possible

CHILD'S NAME _____ DATE _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE _____

BIRTHDATE _____ AGE _____ GENDER: M F HEIGHT _____ in WEIGHT _____ lb

PARENT'S NAME _____ SIBLINGS' NAME _____

PARENT'S OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ EMAIL _____

HOW DID YOU HEAR ABOUT OUR WELLNESS CENTER? _____

WHAT HEALTH CONCERNS DO YOU HAVE FOR YOUR CHILD RIGHT NOW? _____

WHEN DID THIS SITUATION OR CONCERN BEGIN? _____

HAS THIS SITUATION OR CONCERN HAPPENED BEFORE? Yes No

Please explain: _____

HAVE YOU SEEN OTHER DOCTORS FOR IT? Yes No

Doctor's name(s) _____

Type(s) of treatment _____ Results _____

HAS THIS SITUATION OR CONCERN: ___ gotten worse ___ stayed constant ___ comes and goes

DOES IT INTERFERE WITH (check all that apply): ___ sleep ___ school ___ play ___ social functioning ___ other

Please explain: _____

PRENATAL & BIRTH HISTORY

During the pregnancy, did the mother:

• Experience any falls or physical traumas? Yes No

Describe: _____

• Experience any illness? Yes No

Describe: _____

• Take any medications? Yes No

List: _____

• Smoke or consume alcohol? Yes No

Where did the birth take place?

___ hospital ___ birthing center ___ home ___ other

Was the delivery premature? Yes No

If yes, at _____ months and _____ weight

Approximately how long did labor last? _____ hours

Was labor chemically induced? Yes No

Was labor doctor assisted? Yes No

Was a C-section performed? Yes No

Was forceps or vacuum extraction used? Yes No

Did the delivery doctor pull or twist the baby during delivery? Yes No Don't Know

Were any genetic disorders or disabilities detected?

Yes No Explain: _____

Check any of the following that the child may have experienced immediately after birth:

___ jaundice ___ respiratory problems

___ feeding problems ___ displaced or broken joints

___ other condition(s): _____

Birth weight: _____ lb _____ oz Birth length: _____ inches

APGAR scores: _____ , _____

CHILD'S HEALTH HISTORY

Please check any of the following conditions that your child has had in the past or has now:

- | | |
|---|---|
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Pink Eye |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Sleeping disorders | <input type="checkbox"/> Tubes in the ears |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Attention problems |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hyperactivity | Comments: _____ |
| <input type="checkbox"/> Constipation | _____ |
| <input type="checkbox"/> Bed wetting | _____ |

Was your child breast-fed? Yes No For _____ months

Has your child:

- been hospitalized? Yes No
- been seen on a Emergency basis? Yes No
- had any surgeries? Yes No
- been in a car accident? Yes No
- had a severe fall? Yes No
- been injured in any high impact or contact type sports (soccer, football, baseball, gymnastics, cheerleading, martial arts, etc.)? Yes No

Explain: _____

CHILD'S CURRENT HEALTH STATUS

What changes (if any) in your child's health and/or behavior have you seen that might have you concerned?

How often does your child "get sick"? _____ times/year

For how long usually? About _____ days

How would you grade the severity of these episodes?

Mild Moderate Severe

Has your child ever taken antibiotics? Yes No

How many times? _____

Is your child currently taking any medication? Yes No

Describe: _____

Does your child have any allergies to any foods, medications, environmental factors, etc.? Yes No

Describe: _____

VACCINATION HISTORY

Have you chosen to vaccinate your child? Yes No

If yes, check all vaccinations your child has received:

Hepatitis B DPT Polio MMR

Chicken Pox Other: _____

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

What changes (if any) in your child's health and/or behavior would you like to see? _____

Is there anything else you would like to share about your child or family which will help us to better understand you and why you have chosen us to assist your child in his/her healing? _____

AUTHORIZATION OF CARE FOR A MINOR CHILD

I, _____ (parent's name) being the parent or legal guardian of
_____ (child's name) have read and fully understand the
Statement of Clinical Objectives and hereby grant permission for my child to receive Chiropractic care.

Patient's Name (print)

Parent/Legal Guardian's Name (print)

Parent/Guardian's Signature Authorizing Care

Date