YOUTH HEALTH RECORD

ABOUT THE CHILD	
Patient Name:	
Address:	
City:	State/Zip Code:
Home/Cell Phone:	
Date of Birth:	Age:
Gender:	Weight:
Siblings (names and ages):	

MEDICATIONS/VACCINATIONS
Number of doses of prescription medication child has taken during his/her/their lifetime:
Please list all medication(s):
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):

ABOUT THE PARENTS	
Parents/Legal Guardians Names:	
Are you the parent or legal guardian? ☐ Parent ☐ Legal Guardian	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced	
Address: ☐ same as above	
Home Phone:	Cell Phone:
E-mail address:	

CHIROPRACTIC EXPERIENCE
Who referred you to our office?
Has any member of your family ever seen a chiropractor? ☐ Yes. ☐ No.

REASON FOR THIS VISIT

Describe the reason for this visit:
□ Wellness □ Condition

If condition, describe:

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
□ Come and gone

Has this condition occurred before?
□ Yes. □ No.

Please explain:

Have you seen other doctors/chiropractors for this condition?
□ Yes. □ No.

Doctor's Name:

Type of treatment:

Results:

PRENATAL HISTORY

During pregnancy, did you use:
□ drugs/medications □ tobacco/alcohol

If yes, please list:

Location of birth:
□ Home □ Birthing Center □ Hospital

Describe your delivery:
□ Labor was chemically induced.
□ Labor was doctor assisted.
□ C-section delivery
□ Forceps/vacuum extraction
□ Doctor pulled or twisted baby
□ Premature delivery

Please explain:

Describe any complications experienced during delivery:

Did you experience any illness(s) while pregnant?
□ Yes. □ No.

Please explain:

Please describe any genetic or disabilities.

Birth weight:	Birth Length:

Apgar Scores:

Ultrasound during pregnancy?

□ Yes. □ No. Number: _____

PRENATAL HISTORY CONTINUED

Did you breastfeed the baby?
□ Yes. □ No.

If yes, how long?

At what age did you introduce:
- Solids:

- Cow's milk:

Are you aware of any food or juice allergies or intolerance?

□ Yes. □ No.

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or 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.*

□ acid reflux	□ constipation
□ frequent colds, coughs, etc.	□ asthma
□ diarrhea	□ hyperactivity
□ bed wetting	□ difficult weight gain
□ learning disorders	□ colic
□ ear infections	□ sleeping difficulties

LIFESTYLE HABITS

Does your child exercise daily? □ Yes. □ No.
How much?

Does your child drink soda? □ Yes. □ No.
How much?

Does your child take vitamins? □ Yes. □ No.

Does your child do affirmations? □ Yes. □ No.

Does your child interact with technology (tablet, phone, TV, etc.) more than one hour per day? □ Yes. □ No.

How much?

Does your child eat balanced meals?
□ Yes. □ No.

Does your child experience prolonged sadness? □ Yes. □ No.

Have you or any else notice that your child is nervous, twitches, shakes, or exhibits rocking behavior? □ Yes. □ No.

Stress levels (1 – low, 10 – high)
School: _____ Home: _____

CURRENT HEALTH HISTORY

The national safety council reports approximately 50% of children fall head first from a high place (i.e.: bed, changing table, stairs, etc.) during first year of life.

Was this the case for your child? □ Yes. □ No.

Please explain:

Has your child ever been hospitalized or had surgery?
□ Yes. □ No.

Please explain:

Has your child ever been in a car accident?
□ Yes. □ No.

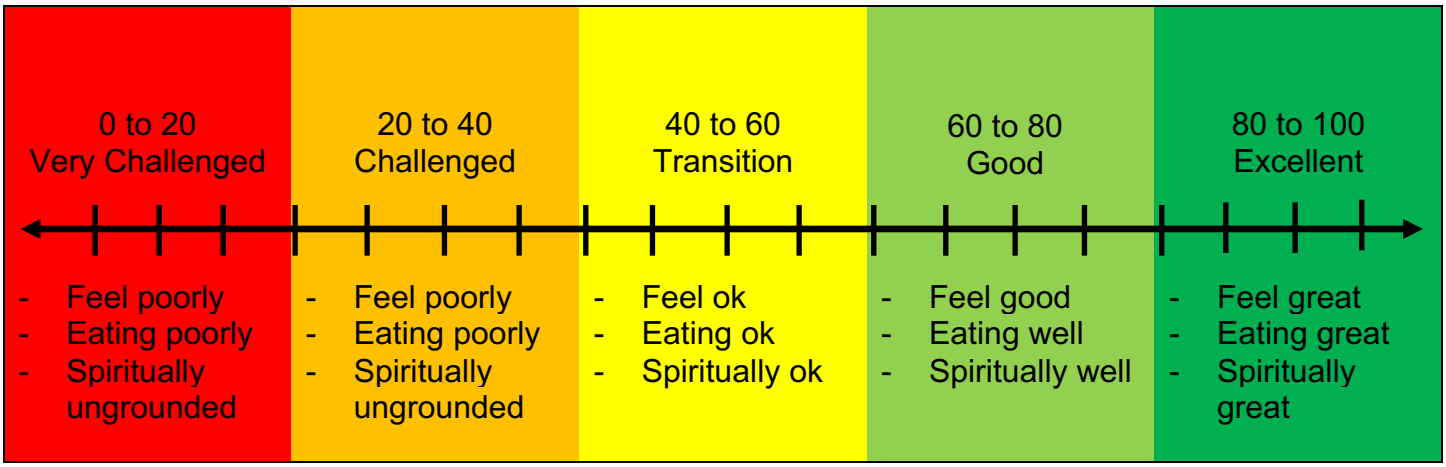
Please explain:

Does your child have difficulty interacting with others?
□ Yes. □ No.

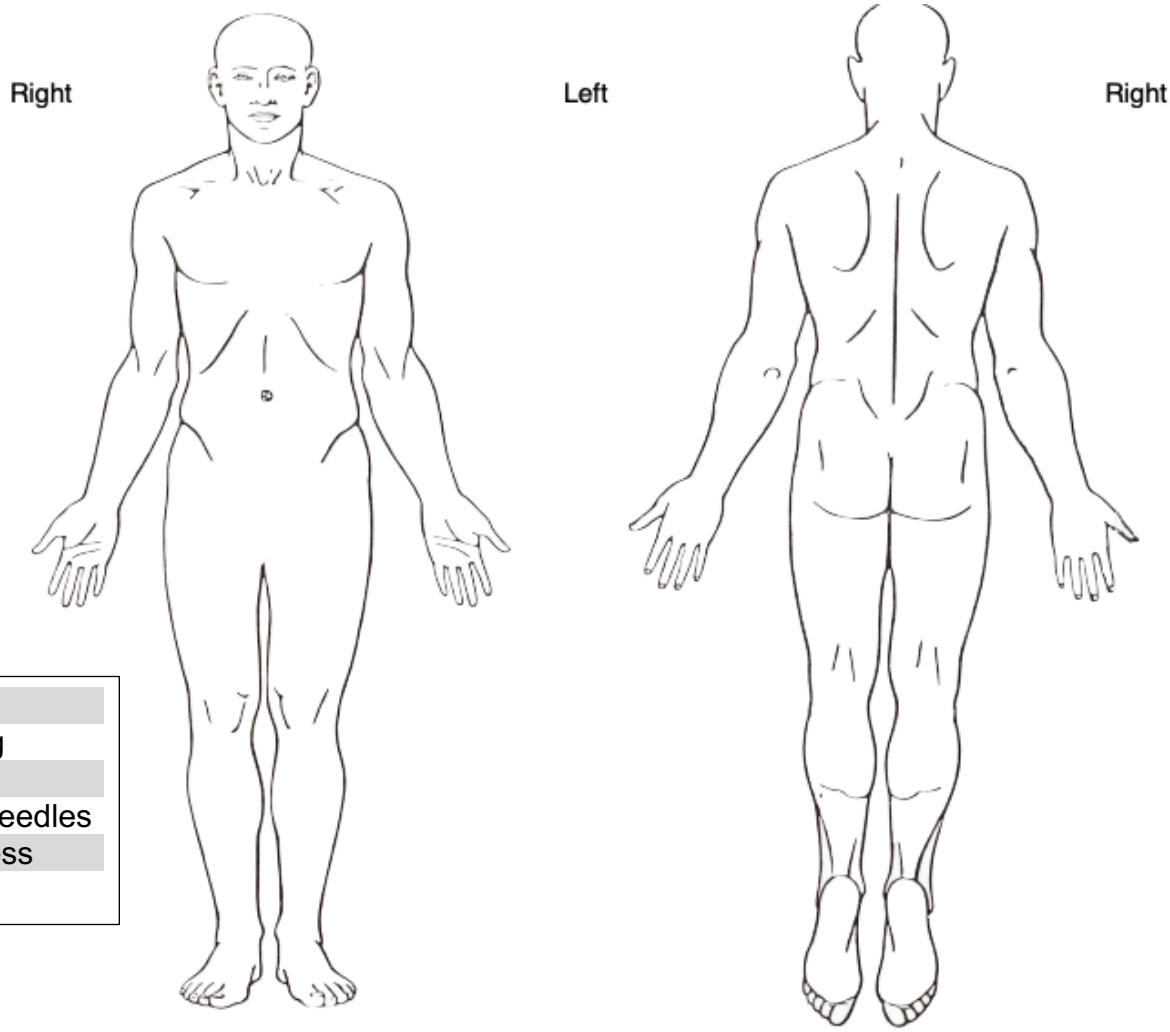
Please explain:

YOUR CHILD'S HEALTH:

Circle the segment of the line that indicates where you believe your child's health and wellness is at this time. Place an "x" on the line where you would ***like*** your child's health and wellness to be.



Please mark area(s) of injury or discomfort you are currently experiencing by using table left of picture.



Key:	
///	Stabbing
XX	Burning
000	Pins & needles
==	Numbness
++	Aching

AUTHORIZATION FOR CARE OF A MINOR

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 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 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 authorize the doctor to share relevant health information with my physician.

Parent or Guardian Authorizing Care Signature:	Date: