



Touch of Health Chiropractic:
A Creating Wellness
Center

CHILDREN'S HEALTH PROFILE

Date: _____

PATIENT INFORMATION

CHILD'S NAME _____ CHILD'S NICKNAME _____
ADDRESS _____ CITY / STATE / ZIP _____
HOME PHONE # _____ CHILD'S SS# _____
GENDER M F HEIGHT _____ WEIGHT _____ BIRTH DATE _____ AGE _____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

FAMILY INFORMATION

MOTHER'S NAME _____ FATHER'S NAME _____
OCCUPATION _____ OCCUPATION _____
EMPLOYER _____ EMPLOYER _____
HOME PHONE # _____ HOME PHONE # _____
WORK PHONE # _____ WORK PHONE # _____
EMAIL _____ EMAIL _____
LIST NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____

Addressing what brought you to this office

If you have no health concerns for your child and are here for **Chiropractic Wellness Services**, please skip to the **"Prenatal History."** Others, please briefly describe your health concern, including the effect it has had on your life.

DO YOU CURRENTLY HAVE ANY HEALTH CONCERNS FOR YOUR CHILD? _____
HOW DOES THIS CONCERN EFFECT YOUR CHILD'S LIFE? _____
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: _____ sleep _____ school _____ play _____ social functioning _____ other activities
Please explain: _____

PRENATAL HISTORY

Did you carry to full term? YES NO _____ Weeks

During the pregnancy, did the mother have any of the following:

_____ Falls	_____ Motor Vehicle Accidents	_____ Near-miss MVA
_____ High Blood Pressure	_____ Diabetes	_____ Anemia
_____ Morning Sickness	_____ Indigestion	_____ Seizures
_____ Swollen Ankles	_____ Thyroid Problems	_____ Heart Problems
_____ Back Pain	_____ Abnormal Bleeding	_____ Were you Hospitalized?
_____ Other _____		

Please explain: _____

Describe any complications and when they occurred: _____

During the pregnancy, did the mother use any of the following:

Consume alcohol? YES NO How much? _____ At what point during pregnancy? _____ For how long? _____

Smoke? YES NO How much? _____ For how long? _____

Take any medications? YES NO

Non-Prescribed _____ Prescribed _____ Over-the-Counter _____

Reason _____ Name _____ For how long? _____

Exposure to ultrasound? YES NO How many? _____

DELIVERY & BIRTH HISTORY

Was the delivery premature? YES NO If yes, at _____ months and _____ weight

Approximately how long did labor last? _____ hours

Hospital Birth YES NO Home Birth YES NO
Birthing Center YES NO Other YES NO
Did you use a midwife? YES NO Obstetrician YES NO

Vaginal delivery? YES NO Was labor chemically induced? YES NO
Was a C-section performed? YES NO If yes, was it Planned _____ or Emergency _____
Forceps Delivery? YES NO Vacuum extraction? YES NO

Did you have an epidural? YES NO Fetal Distress YES NO
Meconium Staining? YES NO Was it a difficult birth? YES NO

Head Presentation YES NO Face Presentation YES NO
Breech Presentation YES NO

Did the delivery doctor pull or twist the baby during delivery? YES NO

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 _____ Birth Length _____ APGAR scores: At 1 minute _____ / 10 At 5 minutes _____ / 10

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has had in the past or has now:

_____ Vision problems _____ Pink eye _____ Headaches _____ Ear infections
_____ Sleeping disorders _____ Tubes in the ears _____ Irritability _____ Allergies
_____ Hyperactivity _____ Attention Problems _____ Skin Problems _____ Colic
_____ Asthma _____ Frequent Colds _____ Breathing Problems _____ Constipation
_____ Bed Wetting _____ Digestive Problems _____ Dizziness _____ Fatigue
_____ Numbness in arms/hands _____ Foot/ankle/knee pains _____ Arm/wrist pains _____ Ringing in ears
_____ Tingling in arms/legs _____ Neck/back pains _____ Shoulder pains _____ "Growing pains"
_____ Weight gain/loss _____ Other _____

Please explain the above _____

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
•Has a severe fall? YES NO
•Been injured in nay high impact or contact type sports (soccer, football, baseball, gymnastics, cheerleading, martial arts, etc.)? YES NO

Explain _____

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): _____
Were you told you had a choice in vaccinating your child? YES NO
Would you like information on the "other side" of the issue? YES NO

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"? About ____ times/year For how long usually? About ____ days
How would you grade the severity of these episodes? Mild = 1 2 3 4 5 = Severe
Has your child ever taken antibiotics? YES NO Explain _____
Is your child currently taking any medication? YES NO Explain _____
Does your child have any allergies to foods, medications, environmental factors, etc? YES NO Explain _____

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? _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

INSURED'S NAME _____ BIRTH DATE _____ SS# _____
INSURANCE COMPANY NAME _____ PHONE # _____
INSURANCE COMPANY ADDRESS (TO SEND CLAIMS) _____
EMPLOYER _____ GROUP # _____ INSURED'S ID# _____

AUTHORIZATION OF CARE FOR A MINOR CHILD

Being the parent or legal guardian of _____, have read and fully understand the Statement of Clinical Objectives and hereby grant permission for my child to receive Chiropractic care.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

PATIENT'S NAME (print)

DATE

PARENT/LEGAL GUARDIAN'S NAME (print)

PARENT/GUARDIAN'S SIGNATURE AUTHORIZING CARE

**Thank you for choosing our office for your family's wellness chiropractic care.
We look forward to helping your family to develop your health over your lifetime.**