Touch of Health Chiropractic:
A Creating Wellness Center

CHILDREN'S HEALTH PROFILE (3 - 18 YEARS OLD)

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 _____
_____
HAS YOUR CHILD PREVIOUSLY HAD CHIROPRACTIC CARE? YES NO Doctor's name(s) _____
WHOM MAY WE THANK FOR YOUR REFERRAL? _____

Addressing what brought you to this office

Please briefly describe your health concern for your child, including the effect it has had on your child's life.

DO YOU CURRENTLY HAVE ANY HEALTH CONCERNS FOR YOUR CHILD?_____
HOW DOES THIS CONCERN AFFECT 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: _____

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 _____
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? _____

_____

CHILD'S HEALTH HISTORY

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

_____ Headaches
_____ Shooting Head Pains
_____ Sinus trouble
_____ Loss of smell/taste
_____ Hayfever/Allergies
_____ Asthma
_____ Cancer
_____Throat trouble
_____ Infections
_____Sleeping trouble
_____ Facial pain/palsy
_____ Loss of memory
_____ Chronic fatigue
_____ Depression/anxiety
_____ Stress
_____ Dizziness/vertigo
_____Hyperactivity
_____Attention problems

_____ Neck Pain
_____ Fainting or seizures
_____ Loss of balance
_____ Ringing of ears/Earaches
_____ Hearing difficulty
_____ Eye/vision trouble
_____ Pink eye
_____ Neck pain/spasm
_____Tightness in shoulders
_____ Shoulder/arm pain
_____ Pins/needles in arms/hands
_____ Cold hands
_____ Chest/rib pain
_____ Shortness of breath
_____ Heart palpitation/trouble
_____ Upper/mid back pain
_____ Shoulder blade pain

_____ Diabetes
_____ Acid reflux or ulcers
_____ Abdominal pain
_____ Stomach trouble
_____ Indigestion
_____ Nervousness
_____ Irritability/moodiness
_____ Bladder problems
_____ Kidney problems
_____ Buttocks pain
_____ Low back pain
_____ Constipation
_____ Diarrhea
_____ Digestive problems
_____ Bedwetting
_____ Skin rashes
_____ Weight gain/loss

_____ Arthritis
_____ Tailbone/sacrum pain
_____ Painful joints
_____ Swollen joints
_____ Hip pain
_____ Pinched nerve in back
_____ Pins/needles in legs
_____ Swollen ankles
_____ Cold feet
_____ Numbness in legs
_____ Knee pain
_____ Groin pain
_____ Pain in legs/feet
_____ Growing pains

Family History of any of the above? YES NO If yes, who? _____

Please List any MOTOR VEHICLE ACCIDENTS and when: _____
Please list any RECENT FALLS OR TRAUMA: _____
Please list all SURGERIES OR FRACTURES and when: _____
Please list all MEDICATIONS and what they're being used for: _____
Does your child play SPORTS? YES NO If yes, please list: _____

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

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)

_____ PARENT/LEGAL GUARDIAN'S NAME (print)

_____ DATE

_____ 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.