Touch of Health Chiropractic:
A Creating Wellness Center

CHILDREN'S HEALTH PROFILE (BIRTH - 2 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

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 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 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
_____ High Blood Pressure
_____ Morning Sickness
_____ Swollen Ankles
_____ Back Pain
_____ Other _____

_____ Motor Vehicle Accidents
_____ Diabetes
_____ Indigestion
_____ Thyroid Problems
_____ Abnormal Bleeding
Please explain:_____

_____ Near-miss MVA
_____ Anemia
_____ Seizures
_____ Heart Problems
_____ Were you Hospitalized?

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			
Bruised Head	YES	NO	Cone Head	YES	NO
Misshapen Head	YES	NO	Other Complications _____		

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:

_____ Ear infections __ R or __ L	_____ Skin Problems	_____ Colic	_____ Headaches
_____ Frequent Colds	_____ Constipation	_____ Digestive Problems	_____ Neck/back pains
_____ Arm/Leg pains	_____ Spits up frequently	_____ Cries a lot	_____ Gassy
_____ Frequently Arches	_____ Cries/Irritable During Diaper Change		

Other _____ Please explain the above _____

Was your child breast-fed? YES NO If yes, how long did you breast feed your child? _____ OR
_____ Still breast feeding
If currently breast feeding, is there a preference for one breast over the other? _____ L _____ R _____ No Preference

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: _____

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? _____

_____

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.