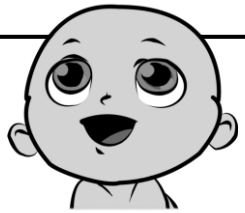
BACK IN ACTION CHIROPRACTIC

Infant – 4 yrs. Health Record



Name: _____ Parent's Home Phone:

Street Address / P.O. Box _____ Parent's Mobile Phone: _____

City / State / Zip: _____ Parent's Work Phone: _____

Social Security Number: _____ Child's Birthdate: _____

Mom's Name: _____ Insured's Employer: _____

Dad's Name: _____ Family Email: _____

Names / Ages of Other Children at Home: _____

Who is Their Family Medical Doctor? _____ Facility / City: _____

How Were You Referred? ☐My M.D. ☐Ins. Plan ☐Another Person: _____ Other: _____

Patient Demographics

(*Required per Federal Guidelines)

***Gender:** ☐Male ☐Female ☐Other: _____ ***Ethnicity:** ☐Hispanic ☐Not Hispanic

***Race (Select One):** ☐White/Caucasian ☐Black/African American ☐American Indian ☐Asian
☐Other: _____

***Preferred Language:** ☐English ☐Spanish ☐Russian ☐Polish ☐Chinese ☐Other: _____

***Drug Allergies:** ☐None **-OR-** ☐ List: _____

***Current Prescription Medications** *Name of Prescription (Brand or Generic)*	**Dose** *(mg, mL, etc.*	**Form** *(Tab, Caps, Inj., Etc.)*	**Frequency** *(# Per Day/Week/Mo.)*
_____	_____	_____	_____ x Per _____
_____	_____	_____	_____ x Per _____
_____	_____	_____	_____ x Per _____
_____	_____	_____	_____ x Per _____
_____	_____	_____	_____ x Per _____

***Current Vitamins/Supplements** *Brand & Type*	**Dose** *(mg, mL, etc.*	**Form** *(Tab, Caps, Powder, Etc.)*	**Frequency** *(# Per Day/Week/Mo.)*
_____	_____	_____	_____ x Per _____
_____	_____	_____	_____ x Per _____
_____	_____	_____	_____ x Per _____

OFFICE USE ONLY:

Height: _____ inches; **Weight:** _____ lbs.; **Blood Pressure:** _____ / _____ (Sit / Stand)

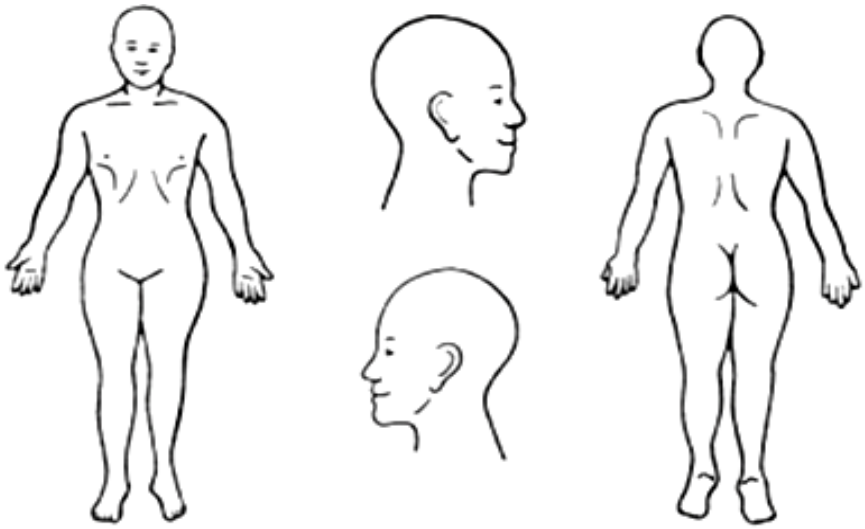
History of Present Illness / Injury

Fill out this section by marking the area with the described sensation using the appropriate symbols from the left.

X X X Burning Pain
((((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain

Please Complete:
_____ Constant
_____ Come & Go
_____
_____ Getting Better
_____ Getting Worse
_____ Staying Same
_____

Better:		Worse:
_____	AM	_____
_____	Mid-Day	_____
_____	PM	_____



If Applicable, Rate Your Discomfort/Symptom(s):

Enter the number below that corresponds with your degree of discomfort. **"0"** is NO pain/symptom(s), **"100"** is intolerable Pain/Symptoms.

None **Discomfort Scale** **Extreme!**

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Why Have You Decided to Have Your Child Evaluated by a Chiropractor?

☐ He/She is Continuing Ongoing Care from Another Chiropractor
☐ I Recently Had My Spine Checked By a Chiropractor and Understand the Value in Getting My Child Checked.
☐ I Have Concerns About His/Her Health and I'm Looking for Answers
☐ He/She Has a Specific Condition and I've Learned that Chiropractic May Be Able to Help
☐ I Want to Improve My Child's Immune Function.

Do You Have a Specific Concern for Your Child That Brings You In?

☐ No, I'm interested in having my child's spine and nervous system assessed to achieve optimal health and functioning.
☐ Yes. please answer the following questions:

Describe Specific Symptom(s) or Concern(s): _____
How Did It Begin? _____ When Did It Start? _____
What Have You Tried So Far to Remedy the Problem(s): _____

YES NO

☐ ☐ Any Recent Loss of Appetite or Change in Eating Habits? How? _____
☐ ☐ Any Recent Change in Bathroom Habits? How? _____
☐ ☐ Any Change in Sleeping Habits? How Many Times Does It Wake Them Up? _____

What Makes the Condition Better?

Head / Neck _____
Mid Back _____
Low Back _____
Other _____
_____

What Makes the Condition Worse?

Head / Neck _____
Mid Back _____
Low Back _____
Other _____
_____

Past Medical History

How Many Times Has Your Child Had the Condition That They Are Seeing Us for Today? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Has Your Child Suffered From Any of the Following Conditions Now or In the Past?

☐ ADD/ADHD ☐ Asthma ☐ Autism ☐ Back Pain ☐ Bed-Wetting ☐ Colic ☐ Ear Infections
☐ Frequent Colds ☐ Scoliosis ☐ Growing Pains ☐ Headaches ☐ Tonsil Problems ☐ Head Tilt ☐ Stomach Pains
☐ Frequent Falls ☐ Crying Spells ☐ Refusal to Eat ☐ Allergies ☐ Skin Rashes ☐ Learning Difficulties

YES NO

☐ ☐ **Does Your Child Suffer From Any Other Health Condition(s)?** (Diabetes, Cancer, Others) If YES, Please Explain:

_____

_____

☐ ☐ **Has Your Child Ever Seen a Chiropractor Before?**

*When Was the Last Time They Were Seen? _____ Which Dr.? _____

*For What Problem(s)? _____ Were They Helped? _____

*How Often Were They Being Seen? _____ Why Did You Leave? _____

*List Any Other Chiropractors Your Child has Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

☐ ☐ **Has Your Child Ever Seen Any Other Healthcare Providers for This Issue?** (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

☐ ☐ **Describe Any Major Illnesses, Injuries, Falls, Hospitalizations, Auto Accidents, and/or Surgeries:**

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

Birth & Rearing History

Were There Any Complications During Pregnancy? ☐ No ☐ Yes, Explain: _____

Was Your Child's Birth: ☐ On Time ☐ Early ☐ Late Explain: _____

Was the Child's Delivery: ☐ Vaginal ☐ Cesarean (C-Section) How Long was Labor? _____

Was the Child Born: ☐ At Home ☐ In Hospital ☐ Who Was Your Midwife / Doctor? _____

What Was The Child's Birth Measurements? ☐ Weight: _____ ☐ Length: _____

YES NO

☐ ☐ Were Extraction Aids (Forceps/Suction) Used? _____

☐ ☐ Was There More Than One Fetus? If Yes, Explain: _____

☐ ☐ Did the Mother Use any Alcohol or Smoke During Pregnancy? If So, How Much? _____

☐ ☐ Did the Mother Use any Pre-Natal Vitamins? If No, Why Not? _____

☐ ☐ Is/Was Your Child Vaccinated? If Yes, Describe Any Adverse Reactions: _____

☐ ☐ If Your Child is Male, Was He Circumcised? Any Complications? _____

☐ ☐ Any Complications to Umbilical Healing? If Yes, Explain: _____

BACK IN ACTION CHIROPRACTIC

Eating/Feeding

YES NO

☐ ☐ Is/Was Your Child Breastfed? Is Your Child Still Being Breastfed? ☐ Yes ☐ No ☐ Goal Duration: _____

If Yes to Either Question, Was/Is There Any Latching Difficulties? ☐ Yes ☐ No Explain: _____

Did They Feed Better or Worse on One Breast vs. The Other Side? ☐ Yes ☐ No Explain: _____

☐ ☐ Did/Does Your Child Use Formula? If Yes, Describe Any Difficulties/Allergies: _____

☐ ☐ Is The Child a Noisy Feeder (Clicks, Slurps, Gasping, Etc.)? Explain: _____

☐ ☐ Was Your Child Checked for Tongue and/or Lip Tie Issues? If So, Any Problems Found/Treated? ☐ Yes ☐ No

☐ ☐ Does Your Child Use a Pacifier? Any Difficulties/Notes? _____

☐ ☐ Is the Child Easy to Burp After Eating? Explain: _____

Digestion/Elimination

YES NO

☐ ☐ Would You Consider Your Child (<u>not your husband</u>) Excessively Gassy? Explain: _____

*Any Attempted Remedies You've Tried to Help? _____

☐ ☐ Any Constipation or Diarrhea Struggles? Explain: _____

*Any Attempted Remedies You've Tried to Help? _____

☐ ☐ Any Excessive Reflux (Spit-Up) Issues? Explain: _____

*Any Attempted Remedies You've Tried to Help? _____

Sleep

YES NO

☐ ☐ Do They Sleep with a Pillow? How Many? _____ Where are They Placed? ☐Head ☐Other: _____

*What Positions Do They Sleep In? ☐Back ☐Side(s) ☐Stomach ☐Other: _____

*Sleep Surface Type? ☐Crib ☐Bed-Side Bassinet ☐Co-Sleep ☐Toddler Bed ☐Other: _____

*Age of Sleep Surface (approx.): _____

*Usual Bed-Time: _____ Awake Time(s): _____

*Describe Daytime Nap(s): _____

Other Observations

YES NO

☐ ☐ Have You Noticed Any Abnormal Head Tilt or Rotation of Their Head/neck? If Yes, Explain: _____

☐ ☐ Any Noticeable Flat Spots or Asymmetrical Cranial Bone Patterns? If Yes, Explain: _____

☐ ☐ Any Unusual Rashes or Skin Issues? If Yes, Explain: _____

☐ ☐ Has Your Child Had Any Umbilical or Inguinal Hernias? If Yes, Explain: _____

☐ ☐ Any Other Physical Concerns You Have About Your Child? If Yes, Explain: _____

_____

Parental Instincts

Do You Feel Your Child is Developmentally Appropriate for Their Age,

Intellectually: ☐ **Yes** ☐ **No**, Explain: _____

Emotionally: ☐ **Yes** ☐ **No**, Explain: _____

Physically: ☐ **Yes** ☐ **No**, Explain: _____

What Is Your Primary Goal(s) for Your Child at Our Clinic? _____

Family Health History

Health Status of Family Members. (List Any Current or Past Health Conditions. Or if Deceased, at What Age and From What?)

Mother: _____

Father: _____

Sister(s): _____ How Many? _____

Brother(s): _____ How Many? _____

System Review Questions

Have You Had Any Problems with the Following Areas Now or in the Past? (Please Mark **Y** for Yes or **N** for No in Each of the Following:)

1. ____ **Eyes** (glasses, Lazy Eye, pink eye, glaucoma, Etc.)
2. ____ **Ears, Mouth, Nose, Throat** (ear infections, sinus, Etc.)
3. ____ **Cardiovascular** (heart, murmur, irregular beat, Etc.)
4. ____ **Respiratory** (lungs, breathing, asthma, RSV, Etc.)
5. ____ **Neurological** (nerve issues, weakness, numbness, Etc.)
6. ____ **Endocrine** (thyroid, hormonal imbalances, liver, Etc.)
7. ____ **Gastro-Intestinal** (acid reflux, colic, constipation, diarrhea, etc.)
8. ____ **Genito-Urinary** (bed wetting, kidneys, bladder, hernias, Etc.)
9. ____ **Musculoskeletal** (breaks, arthritis, scoliosis, Etc.)
10. ____ **Skin** (rashes, dryness, psoriasis, eczema, hair, Chicken Pox, Etc.)
11. ____ **Dietary Sensitivity** (Dairy, Gluten, Corn, Flour, Sugar, Etc.)
12. ____ **Others**: _____

Please Describe in More Detail: _____

_____

Parental Options for Your Child's Care

Check <u>ALL</u> the Boxes Below That Corresponds How You Would Like the Doctors to Approach Your Issue(s):

- ☐ I simply wish for him/her to have just a few adjustments for symptom control, <u>then call as needed</u>.
- ☐ I would like the doctors to put him/her on a <u>Treatment Plan</u> to help me fully recover.
- ☐ I am interested in being shown any necessary <u>Stretches +/- Exercises</u> to help him/her heal faster.
- ☐ I'd be open to <u>Vitamin/Supplement or other Product</u> recommendations to help their body through the healing phases.
- ☐ Once we complete the initial treatment plan, I'm interested in a <u>Wellness Adjustment Schedule</u> to support their gains.

Notes:

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

D.C. / C.T. Signature: _____ Date: _____