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

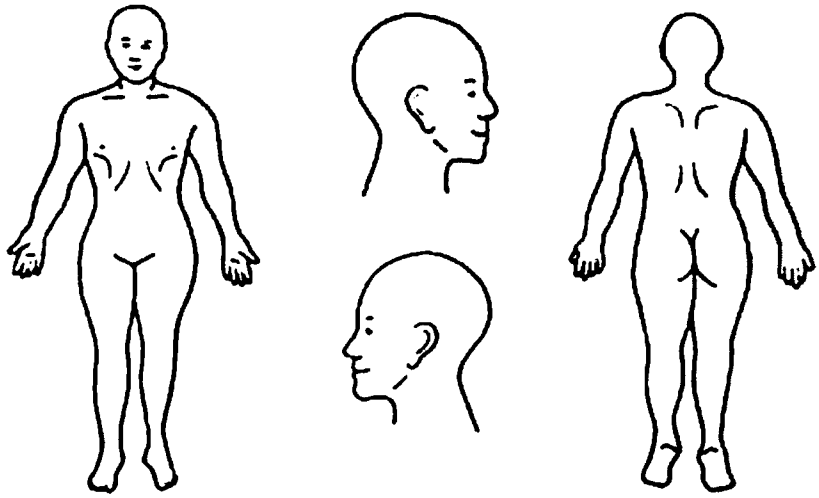
Fill out this section by marking the area with the described sensation using the appropriate symbols from the left.

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 _____
_____

BACK IN ACTION CHIROPRACTIC

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 (NOT YOUR HUSBAND) 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: _____