Hope Chiropractic

"Giving you hope, improving health, creating wellness!"

CHILDREN'S HEALTH HISTORY

Date: _____

Name: _____ Birth date_____ Age:_____
Address: _____City: _____State: _____ Zip:_____
Cell #: _____ Home #: _____ Work #: _____
E-mail Address: _____ SS#:_____
Other Children's Names/Ages:_____
Family M.D. Clinic:_____

ABOUT THE PARENTS / EMERGENCY CONTACT

Name (s): _____ Cell Phone: _____
Employer: _____ Occupation: _____

REASON FOR THIS VISIT

Describe the purpose for this visit: _____
When did this health challenge begin? _____
Has this: □ gotten worse □ stayed the same □ comes and goes □ gotten better
Does this interfere with: □ work □ sleep □ daily routine □ other activities (_____)
Has this condition occurred before? □ Yes □ No Explain: _____
Have you seen any other professional for this? □ Yes □ No; Dr.'s Name (s) _____
Type of treatment _____Results _____
Is the purpose for this visit related to:
□ Job □ Auto □ Fall □ Sports □ Daily Life □ Chronic Discomfort □ Home Injury □ Other;
Please explain: _____
If job related, have you made a report of accident to your employer? □ Yes □ No

EXPERIENCE WITH CHIROPRACTIC

How did you hear about our office? _____
Have you been adjusted by a chiropractor before? □ Yes □ No
Reasons for those visits? _____
Approximate Date of Last Visit:_____ Previous Chiropractor's Name: _____
Has an *adult* in your family seen a Chiropractor? □ Yes □ No
Has a *child* in your family seen a Chiropractor? □ Yes □ No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that...

- Doctors of Chiropractic work with the nervous system? □ **Yes** □ **No**
- the nervous system controls all bodily functions and systems? □ **Yes** □ **No**
- Chiropractic is the largest natural healing profession in the world? □ **Yes** □ **No**
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? □ **Yes** □ **No**

GOALS FOR YOUR CHILD'S HEALTH:

People see Chiropractors for a variety of reasons. Some go for pain relief, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. **Please check** the type of care desired so that we may be guided by wishes whenever possible.

□ **Relief Care:** Symptomatic relief of pain or discomfort
□ **Corrective Care:** Correcting and relieving the **cause** of the problem as well as the symptoms.
□ **Comprehensive Care:** Caring for the whole body not just the symptomatic area. This works on achieving the highest state of health in your body.
□ I want the Doctor to select the type of care appropriate for my child's condition and recommend care that will be the best for his/her health and wellness.

CURRENT MEDICATIONS

_____
_____

PERSONAL HISTORY

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical, or emotional may cause **subluxations**. The practice of Chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxation**.

HEALTH HABITS

	No	Yes		For Young Women:	No	Yes
Do you smoke?	□	□	____ packs per day	Are you pregnant?	□	□
Do you drink alcohol?	□	□	____drinks per week	Are you nursing?	□	□
Do you drink coffee/soda?	□	□	____ cups per day	Are you taking birth control?	□	□
Do you exercise?	□	□	□ Mild □ Moderate □ Daily	Do you have painful periods?	□	□
Do you wear Heel Lifts?	□	□		Do you have irregular cycles?	□	□
Do you wear Arch Supports?	□	□				

HEALTH CONDITIONS

Please tell us of any past/current diseases or conditions. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

_____

_____

PLEASE TELL US ABOUT ANY STRESS RELATED WITH BIRTH:

	No	Yes	Explain:
1.) Drugs/Medicine during pregnancy?	□	□	_____
2.) Tobacco/Alcohol during pregnancy?	□	□	_____
3.) Illness during pregnancy?	□	□	_____
4.) Labor chemically induced?	□	□	_____
5.) Labor was doctor assisted?	□	□	_____
6.) Forceps/Vacuum Extraction/ C-Section?	□	□	_____
7.) Did doctor pull/twist baby?	□	□	_____
8.) Premature Delivery?	□	□	_____
9.) Breastfed? How long?	□	□	_____
10.) Baby Jaundiced?	□	□	_____
11.) Feeding problems?	□	□	_____
12.) Sleeping problems?	□	□	_____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

	No	Yes	Explain:
1.) Falls in the first year of life?	□	□	_____
2.) Respiratory problems?	□	□	_____
3.) Ear Infections?	□	□	_____
4.) Allergy/Asthma?	□	□	_____
5.) Bedwetting?	□	□	_____
6.) Digestive problems?	□	□	_____
7.) Hyperactivity?	□	□	_____
8.) Hospitalizations/Surgeries?	□	□	_____
9.) Vaccinations?	□	□	_____

AUTHORIZATION FOR CARE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I hereby authorize the Doctor(s) to work with my condition through the use of adjustments as he/she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsibly for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I authorize release of records to assist collections.

I hereby authorize Dr. Carolyn Wanken or whomever she designates as assistants to administer Chiropractic care as deemed necessary to my child, _____.

(Name of Child)

Signature of Parent/Guardian: _____ Date: _____