PATIENT HEALTH RECORD CHILD

Lauer Family Chiropractic

ABOUT THE CHILD

Name _____

Address _____

City_____ State_____ Zip_____

Home phone _____

Birth date _____

SS#_____

Age _____ Gender M / F Weight_____

ABOUT THE PARENT

Name_____

Employer_____

Work address _____

Work phone _____Cell_____

Type of work _____

E-mail address_____

Social Security # _____

Insurance Co:_____

Insured's Name:_____

Insured's SS#:_____ DOB:_____

VACCINATIONS

Have you chosen to vaccinate your child? **Yes** **No**

If yes, circle all that your child has received.

DPT **MMR** **Chicken Pox** **Hepatitis** **Other**

Describe any and all reactions to vaccine(s). _____

_____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to

Sports **Auto** **Fall** **Home Injury** **Wellness** **Other**

Please explain _____

When did this condition begin? _____

Has this condition:

Gotten worse **Stayed constant** **Comes and goes**

Does this condition interfere with:

Sleep **Daily routine** **Other activities**

Please explain _____

_____

Has this condition occurred before? **Yes** **No**

Please explain _____

Have you seen other doctors for this condition? **Yes** **No**

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

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

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? **Yes** **No** Reason for those visits? _____

Doctor's name_____ Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? **Yes** **No**

Has any child in your family seen a Chiropractor? **Yes** **No**

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

☐ Drugs / Medicine ☐ Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy?_____

_____

How was your delivery? _____

☐ Labor chemically induced ☐ Labor was Dr. assisted
☐ C-section delivery ☐ Forceps/Vacuum extraction?
☐ Did Dr. pull or twist baby? ☐ Premature delivery

Please explain _____

Did you nurse the baby? **Yes No**

Did your baby have colic? **Yes No**

Feeding problems? **Yes No**

Vaccinations? **Yes No**

CHILD'S HEALTH HISTORY

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

☐ Allergies
☐ Asthma
☐ Attention problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear problems
☐ Frequent colds
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Skin problems
☐ Sleeping disorders
☐ Tubes in the ears
☐ Vision problems
☐ Other

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:			
…taken antibiotics?	☐	☐	_____
…been hospitalized?	☐	☐	_____
…had a severe fall?	☐	☐	_____
…been in a car accident?	☐	☐	_____
Is your child			
…accident prone?	☐	☐	_____
Had Surgery? Please Explain…	☐	☐	_____
…currently taking any medication (s)?	☐	☐	_____
…having difficulty interacting with others?	☐	☐	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished? _____

_____

AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Lauer Family Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian:_____Date:_____

HISTORY AND EVALUATION

Chief Concerns:_____

_____

_____

History of Condition:_____

_____

Birth and Delivery:_____

Childhood Injuries / Falls / Accidents:_____

Temperament / Attitude:_____

Sleep:_____**Nutrition:**_____

Medications:_____

What has been done to help this condition (s):_____

Family Health History:_____

Other:_____

EXAM

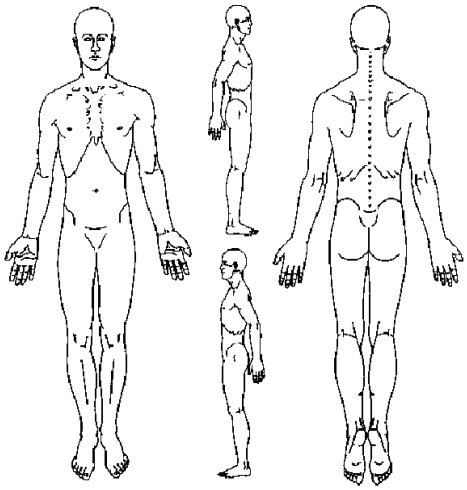
Name:_____

Date:_____

Height_____ **Weight**:_____

Bilateral Weights L__ R__

Short Leg L__ R__



Other Testing:

Posture Analysis

Head Tilt	Rt.	Lt.
Ear High	Rt.	Lt.
Apparent Cervical Curve	Rt.	Lt.
Cerv. Muscle Tension	Rt.	Lt.
Shoulder High on	Rt.	Lt.
Apparent Thoracic Curve	Rt.	Lt.
Thoracic Musc. Tension	Rt.	Lt.
Apparent Lumbar Curve	Rt.	Lt.
Lumbar Musc. Tension	Rt.	Lt.
Illium High On	Rt.	Lt.

Subluxation Palpation

OC		T1			L1			
C1		T2			L2			
C2		T3			L3			
C3		T4			L4			
C4		T5			L5			
C5		T6			S			
C6		T7			SI			
C7		T8						
		T9						
		T10						
		T11						
		T12						

Comments: