

Child Member Health Record

ABOUT THE CHILD

| | | |
|--------------------------|-----------------|---------|
| NAME: | | |
| ADDRESS: | | |
| CITY: | STATE/ZIP CODE: | |
| HOME PHONE: | | |
| DATE OF BIRTH: | AGE: | GENDER: |
| HEIGHT: | WEIGHT: | |
| SIBLINGS NAMES AND AGES: | | |

ABOUT THE PARENT

| | | |
|--|-----------------|--|
| PARENT/LEGAL GUARDIAN NAME: | | |
| ADDRESS: <input type="checkbox"/> SAME AS ABOVE | | |
| CITY: | STATE/ZIP CODE: | |
| HOME PHONE: | CELL PHONE: | |
| EMAIL ADDRESS: | | |
| EMPLOYER NAME: | | |
| WORK PHONE: | POSITION TITLE: | |

CHIROPRACTIC EXPERIENCE

| |
|---|
| WHO REFERRED YOU TO OUR OFFICE? |
| HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING |
| HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| IF YES, WHAT WAS THE REASON FOR THOSE VISITS? |
| DOCTOR'S NAME: |
| APPROXIMATE DATE OF LAST VISIT: |

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: CONDITION WELLNESS
IF CONDITION, PLEASE DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

SPORTS AUTO FALL HOME INJURY OTHER

DID THIS CONDITION START:

SUDDENLY GRADUALLY POST INJURY

WHEN DID THIS CONDITION START?

IS THIS PROBLEM: OCCASIONAL FREQUENT CONSTANT

WHAT MAKES THIS PROBLEM BETTER?

WHAT MAKES THIS PROBLEM WORSE?

SINCE THE PROBLEM BEGAN HAS IT:

GOTTEN WORSE STAYED CONSTANT COME AND GONE

DOES THIS CONDITION INTERFERE WITH:

SLEEP DAILY ROUTINE EATING OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?

YES NO

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?

YES NO

DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT/TESTING:

RESULTS:

COMPLETE THIS PAGE FOR CHILDREN 9-13 YEARS OF AGE

BIRTH HISTORY

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? YES NO
 DID YOU SUFFER ANY TRAUMAS, FALLS, OR ACCIDENTS? YES NO
 PLEASE EXPLAIN:

DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY:

- DRUG FREE SPONTANEOUS
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY PREMATURE DELIVERY

PLEASE EXPLAIN:

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA?

- BRUISING STUCK IN THE BIRTH CANAL
 RESPIRATORY DISTRESS CORD AROUND NECK
 FAST OR EXCESSIVELY LONG BIRTH LACK OF USE OF ONE ARM
 ODD SHAPED HEAD HEAD ROTATED TO ONE SIDE

CURRENT HISTORY CONT.

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)

YES NO

PLEASE LIST:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

YES NO

PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

YES NO

PLEASE EXPLAIN:

DOES YOUR CHILD CARRY A BACKPACK? YES NO

WHAT IS THE APPROXIMATE WEIGHT? _____

AVE. # OF HRS OF TV/VIDEO GAMES WATCHED PER WEEK? _____

ARE THERE ANY SMOKERS LIVING IN THE HOME? YES NO

ARE THERE ANY INDOOR PETS IN YOUR HOME? YES NO

DO YOU USE GREEN CLEANING PRODUCTS IN YOUR HOME? YES NO

PLEASE RATE YOUR CHILD'S STRESS LEVELS ON A SCALE OF 1-10 (10=HIGH)

SCHOOL: 1 2 3 4 5 6 7 8 9 10

PERSONAL: 1 2 3 4 5 6 7 8 9 10

PLEASE EXPLAIN:

LIST PRESCRIPTION MEDICATION OR SUPPLEMENTS TAKEN:

LIST ANY ALLERGIES YOUR CHILD HAS :

CURRENT HEALTH HISTORY

DOES YOUR CHILD EAT WELL YES NO

ARE YOU AWARE OF THE IMPACT NUTRITION CAN HAVE ON YOUR CHILD'S BEHAVIOR? YES NO

WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION FOR YOUR CHILD?

YES NO

DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS YES NO

DOES YOUR CHILD SLEEP WELL YES NO

DOES YOUR CHILD SLEEP ON HIS/HER SIDE STOMACH BACK

PLEASE DESCRIBE HIS/HER SLEEPING HABITS:

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? YES NO

DO YOU FOLLOW THE STANDARD SCHEDULE? YES NO

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT DISLOCATION?

YES NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? YES NO

PLEASE EXPLAIN:

SYSTEMS REVIEW

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS/SYMPTOMS YOUR CHILD HAS EXPERIENCED:

- | | |
|--|---|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> DIFFICULT WEIGHT GAIN |
| <input type="checkbox"/> BED WETTING | <input type="checkbox"/> LEARNING DISORDERS |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> FREQUENT COLDS/COUGHS/FLUS |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> HYPERACTIVITY |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FEVERS |
| <input type="checkbox"/> POOR COORDINATION | <input type="checkbox"/> SORE THROATS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> ALLERGIES |
| <input type="checkbox"/> SLEEPING DIFFICULTIES | <input type="checkbox"/> URINARY PROBLEMS |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> UPPER BACK PAIN |
| <input type="checkbox"/> LOW BACK PAIN | <input type="checkbox"/> SHORTNESS OF BREATH |

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? YES NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM? YES NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS? YES NO

ARE YOU AWARE THAT CHIROPRACTORS TREAT A CONDITION CALLED SUBLUXATION? YES NO

DID YOU KNOW THAT YOU CAN HAVE A SUBLUXATION WITHOUT EXPERIENCING PAIN? YES NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY? YES NO

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F = FATHER S = SIBLINGS G = GRANDPARENTS

- | | | |
|---|---|---|
| CANCER: TYPE _____ | DEPRESSION | DIABETES |
| <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| HEART DISEASE | LIVER DISEASE | HIGH CHOLESTEROL |
| <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| HIGH BLOOD PRESSURE | LUNG PROBLEMS | SEIZURES |
| <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| NECK PROBLEMS | BACK PROBLEMS | SCOLIOSIS |
| <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| OSTEOARTHRITIS | RHEUMATOID ARTHRITIS | |
| <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | |
| AUTOIMMUNE DISEASES | | |
| <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | | |

OTHER: _____

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1. _____
2. _____
3. _____

IF YOU HAVE ANY OTHER CONCERNS NOT PREVIOUSLY LISTED ON THESE FORMS, PLEASE WRITE THEM IN USING THE SPACE BELOW.

THANK YOU FOR CHOOSING BALLARD FAMILY CHIROPRACTIC AND HELPING US TO CONTINUE ON OUR MISSION TO
GROW A HEALTHIER COMMUNITY, ONE FAMILY AT A TIME!