Child Member Health Record

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WORK PHONE:

POSITION TITLE:

Ballard Family Chiropractic 14225 E. Rickelman Effingham, IL 62401

COMPLETE THIS PAGE FOR CHILDREN 4 to 8 YEARS OF AGE

BIRTH HISTORY	GROWTH &DEVELOPMENT			
DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?	DOES YOUR CHILD HAVE ANY DEVELOPMENTAL OR DEVELOPMOTOR DELAYS? YES NO IF YES, PLEASE DESCRIBE AND INCLUDE INTERVENTIONS:			
DURING PREGNANCY DID YOU USE: ☐ TOBACCO/ALCOHOL ☐ SUPPLEMENTS	HOW MANY TIMES/WEEK DOES YOUR CHILD EAT FAST FOOD?			
IF YES, PLEASE LIST:	CANDY/COOKIES?SODAS?			
IF YES, PLEASE LIST:	ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?			
ULTRASOUND DURING PREGNANCY?	HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? HOW MANY TIMES?:			
LOCATION OF BIRTH: HOME BIRTHING CENTER HOSPITAL	HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐ YES ☐ NO PLEASE EXPLAIN:			
WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? WEEKS DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY: DDRUG FREE	THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.). WAS THIS THE CASE FOR YOUR CHILD? PLEASE EXPLAIN:			
DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:	HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ☐ YES ☐ NO PLEASE EXPLAIN:			
BIRTH WEIGHT: BIRTH LENGTH:	HAS YOUR CHILD EVER HAD SURGERY? ☐ YES ☐ NO PLEASE EXPLAIN:			
WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY ☐ YES ☐ NO	DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?			
DID YOU BREASTFEED THE BABY? ☐ YES ☐ NO	PLEASE EXPLAIN:			
IF YES, HOW LONG? DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION? □ YES □ NO	HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?			
DID YOU FORMULA FEED THE BABY? ☐ YES ☐ NO	AT WHAT AGE DID YOUR CHILD START DAYCARE?			
IF YES, HOW LONG?	☐ IN-HOME ☐ DAYCARE CENTER			
DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA? □ BRUISNG □ RESPIRATORY DISTRESS □ CORD AROUND NECK □ FAST OR EXCESSIVELY LONG BIRTH □ ODD SHAPED HEAD □ HEAD ROTATED TO ONE SIDE	DOES YOUR CHILD ATTEND SCHOOL/PRESCHOOL? ☐ YES ☐ NO DOES YOUR CHILD CARRY A BACKPACK? ☐ YES ☐ NO			
	WHAT IS THE APPROXIMATE WEIGHT? AVERAGE NUMBER OF HRS OF TV/VIDEO GAMES 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			

YOUR HEALTH GOALS

COMPLETE THIS PAGE FOR CHILDREN 4 TO 8 YEARS OF AGE

CHIROPRACTIC KNOWLEDGE	1913		FAMILY HISTOR
ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? ☐ YES ☐ NO	BEEN DIAGNOSED WITH:		FAMILY MEMBERS HAVE
ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM? YES	M = MOTHER F=FATHER S CANCER: TYPE M F S G HEART DISEASE M F S G HIGH BLOOD PRESSURE M F S G NECK PROBLEMS M F S G OSTEOARTHRITIS M F S G AUTOIMMUNE DISEASES M F S G OTHER:	=SIBLINGS G = GRAND DEPRESSION M F S G LIVER DISEASE M F S G LUNG PROBLEMS M F S G BACK PROBLEMS M F S G RHEUMATOID ARTI	DIABETES M F S G HIGH CHOLESTEROL M F S G SEIZURES M F S G SCOLIOSIS M F S G

SYSTEMS REVIEW

CAN SHOW UP AS OTHER HE TIONS/SYMPTOMS YOUR CH CONSTIPATION CONSTIPATION CAR INFECTIONS COLIC ASTHMA POOR COORDINATION SILEPING DIFFICULTIES NECK PAIN LOW BACK PAIN	CION CAN BE BROAD AND FAR REACHING. THEY EALTH CONCERNS. PLEASE MARK ALL CONDI- IIILD HAS EXPERIENCED: DIFFICULT WEIGHT GAIN LEARNING DISORDERS DIARRHEA FREQUENT COLDS/COUGHS/FLUS HYPERACTIVITY HEADACHES SORE THROATS ALLERGIES URINARY PROBLEMS UPPER BACK PAIN SHORTNESS OF BREATH	WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD? 1

WHAT CHANGES (IF ANY) WOULD YOU LIKE TO SEE ACCOMPLISHED IN YOUR CHILD'S HEALTH OR BEHAVIOR?

IF YOU HAVE ANY OTHER CONCERNS NOT PREVIOUSLY LISTED ON THESE FORMS, PLEASE WRITE THEM IN U SING 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!