

# 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:		

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAS YOUR CHILD EVER BEEN CHECKED FOR VERTEBRAL SUBLUXATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
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?
CHIROPRACTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:

## GENERAL HISTORY

DOES YOUR CHILD EAT WELL <input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU AWARE OF THE IMPACT NUTRITION CAN HAVE ON YOUR CHILD'S BEHAVIOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION FOR YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD SLEEP WELL <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD SLEEP ON HIS/HER <input type="checkbox"/> SIDE <input type="checkbox"/> STOMACH <input type="checkbox"/> BACK PLEASE DESCRIBE HIS/HER SLEEPING HABITS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
LIST PRESCRIPTION MEDICATION/SUPPLEMENTS TAKEN:
LIST ANY ALLERGIES YOUR CHILD HAS :

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> CONDITION <input type="checkbox"/> WELLNESS IF CONDITION, PLEASE DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER
DID THIS CONDITION START: <input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> POST INJURY
WHAT DATE DID THIS CONDITION START?
IS THIS PROBLEM: <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> FREQUENT <input type="checkbox"/> CONSTANT
WHAT MAKES THIS PROBLEM BETTER?
WHAT MAKES THIS PROBLEM WORSE?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> EATING <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME AND SPECIALTY:
TYPE OF TREATMENT/TESTING:
RESULTS:

## 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:

Ballard Family Chiropractic  
14225 E. Rickelman  
Effingham, IL 62401

**COMPLETE THIS PAGE FOR CHILDREN 4 to 8 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:

DURING PREGNANCY DID YOU USE:  MEDICATIONS  
 TOBACCO/ALCOHOL  SUPPLEMENTS

IF YES, PLEASE LIST:

ULTRASOUND DURING PREGNANCY?  YES  NO NUMBER: \_\_\_\_\_

MEDICAL REASON FOR ULTRASOUND?

LOCATION OF BIRTH:  HOME  BIRTHING CENTER  HOSPITAL

WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? \_\_\_\_\_ WEEKS

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:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT:

BIRTH LENGTH:

WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY  YES  NO

DID YOU BREASTFEED THE BABY?  YES  NO

IF YES, HOW LONG?

DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION?  YES  NO

DID YOU FORMULA FEED THE BABY?  YES  NO

IF YES, HOW LONG?

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

**GROWTH & DEVELOPMENT**

DOES YOUR CHILD HAVE ANY DEVELOPMENTAL OR DEVELOPMOTOR DELAYS?  YES  NO

IF YES, PLEASE DESCRIBE AND INCLUDE INTERVENTIONS:

HOW MANY TIMES/WEEK DOES YOUR CHILD EAT FAST FOOD? \_\_\_\_\_

CANDY/COOKIES? \_\_\_\_\_ SODAS? \_\_\_\_\_

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

YES  NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?

HOW MANY TIMES?:

HAS YOUR CHILD EVER BEEN HOSPITALIZED?  YES  NO

PLEASE EXPLAIN:

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?  YES  NO

PLEASE EXPLAIN:

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

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY?  YES  NO

PLEASE EXPLAIN:

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

AT WHAT AGE DID YOUR CHILD START DAYCARE? \_\_\_\_\_

IN-HOME  DAYCARE CENTER

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

**COMPLETE THIS PAGE FOR CHILDREN 4 TO 8 YEARS OF AGE**

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

OTHER: \_\_\_\_\_

**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:

**YOUR HEALTH GOALS**

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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 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!**