

# PATIENT HEALTH RECORD CHILD

## ABOUT THE CHILD

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Birth date \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Weight \_\_\_\_\_

Social Security # \_\_\_\_\_

## ABOUT THE PARENT

Name \_\_\_\_\_

Employer \_\_\_\_\_

Work address \_\_\_\_\_

Work phone \_\_\_\_\_

Type of work \_\_\_\_\_

Marital Status \_\_\_\_\_

Social Security # \_\_\_\_\_

Driver's License # \_\_\_\_\_

E-mail address \_\_\_\_\_

Payment method  Cash  Check  Credit Card

## VACCINATIONS

Have you chosen to vaccinate your child?  Yes  No

If yes, check all that your child has received.

DPT  MMR  Chicken Pox  Hepatitis  Polio  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

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 Chiropractic 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 Doctor-assisted  
 C-section delivery             Forceps/Vacuum extraction?  
 Premature delivery             Did Doctor pull or twist baby?

Please explain \_\_\_\_\_

Did you nurse the baby?     Yes     No

Did your baby have colic?     Yes     No

Feeding problems?     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.

Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Frequent colds
<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Headaches
<input type="checkbox"/>	<input type="checkbox"/> Attention problems
<input type="checkbox"/>	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/>	<input type="checkbox"/> Bed wetting
<input type="checkbox"/>	<input type="checkbox"/> Irritability
<input type="checkbox"/>	<input type="checkbox"/> Breathing problems
<input type="checkbox"/>	<input type="checkbox"/> Skin problems
<input type="checkbox"/>	<input type="checkbox"/> Colic
<input type="checkbox"/>	<input type="checkbox"/> Sleeping disorders
<input type="checkbox"/>	<input type="checkbox"/> Constipation
<input type="checkbox"/>	<input type="checkbox"/> Tubes in the ears
<input type="checkbox"/>	<input type="checkbox"/> Digestive problems
<input type="checkbox"/>	<input type="checkbox"/> Vision problems
<input type="checkbox"/>	<input type="checkbox"/> Ear problems
<input type="checkbox"/>	<input type="checkbox"/> Other _____

## CHILD'S CURRENT HEALTH STATUS

No    Yes    If Yes, please explain:

Has your child ever:

... taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... has a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... been accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... currently taking any medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... having difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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? \_\_\_\_\_

\_\_\_\_\_

## GOALS FOR MY CHILD'S CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, 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 your 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** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition.



Johnson Chiropractic Clinic  
226 Brandilynn Blvd. Ste. D, Cedar Falls, IA 50613  
Phone: (319) 266-7788 Fax: (319) 266-8088

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## CONSENT TO TREAT

Child's Name \_\_\_\_\_

I hereby give my consent and do authorize Dr. Johnson, DC and his staff to treat my son/daughter for any necessary chiropractic care needed. I authorize the exchange of information with any insurance companies and/or attorneys involved regarding evaluation, treatment, follow-up care and billing. This consent shall remain in effect until further notice by me.

Print \_\_\_\_\_  
Parent or Guardian Name

Signed \_\_\_\_\_

Dated \_\_\_\_\_