

# Children's Health Record

## ABOUT THE CHILD

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

## CHIROPRACTIC EXPERIENCE

|   |
|---|
| WHO REFERRED YOU TO OUR OFFICE?   |
| HAS YOUR CHILD EVER BEEN CHECKED FOR VERTEBRAL SUBLUXATION?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW |
| HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?<br><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 NUTRION CAN HAVE ON YOUR CHILD'S BEHAVIOR? <input type="checkbox"/> YES <input type="checkbox"/> NO   |
| WOULD YOU LIKE MORE INFORMATION ABOUT NUTRION FOR YOUR CHILD?<br><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<br>PLEASE DESCRIBE HIS/HER SLEEPING HABITS: |
| HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO   |
| IF YES, ARE YOU FOLLOWING THE STANDARD SCHEDULE? <input type="checkbox"/> YES <input type="checkbox"/> NO   |
| 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<br>IF CONDITION, PLEASE DESCRIBE:  |
| IS THIS PROBLEM: <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> FREQUENT <input type="checkbox"/> CONSTANT<br>WHAT MAKES THIS PROBLEM BETTER?<br><br>WHAT MAKES THIS PROBLEM WORSE?                 |
| IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:<br><input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER |
| HOW DID THIS CONDITION START?<br><input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> POST INJURY<br>WHEN?   |
| HAS THIS CONDITION:<br><input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE  |
| DOES THIS CONDITION INTERFERE WITH:<br><input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> EATING <input type="checkbox"/> OTHER ACTIVITIES<br>PLEASE EXPLAIN:         |
| HAS THIS CONDITION OCCURRED BEFORE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |
| HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |
| DOCTOR'S NAME AND SPECIALTY:  |
| PRIMARY CARE DOCTOR'S NAME:   |
| TYPE OF TREATMENT/TESTING:  |
| RESULTS:  |

## ABOUT THE PARENTS

|  |                      |
|--|----------------------|
| FATHER'S NAME:                                     | MOTHER'S NAME:       |
| ADDRESS:<br><input type="checkbox"/> SAME AS ABOVE |                      |
| CITY:  | STATE/ZIP CODE:      |
| FATHER'S CELL PHONE:                               | MOTHER'S CELL PHONE: |
| EMAIL ADDRESS:                                     |                      |

**COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE**

## BIRTH HISTORY

## GROWTH & DEVELOPMENT

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/ALCOHO  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  PITOCIN/OXYTOCIN USED  SPONTANEOUS  
 LABOR WAS CHEMICALLY INDUCED  EPIDURAL USED  
 LABOR WAS DOCTOR ASSISTED  C-SECTION DELIVERY  
 FORCEPS/VACUUM EXTRACTION  PREMATURE DELIVERY  
 DOCTOR PULLED OR TWISTED BABY

PLEASE EXPLAIN:

HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT: \_\_\_\_\_ BIRTH LENGTH: \_\_\_\_\_

APGAR SCORES: AT 1 MIN \_\_\_\_\_/10 AT 5 MIN \_\_\_\_\_/10

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 DIFFICULTY WITH LATCHING OR LACTATION?  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

THIRD TRIMESTER PRESENTATION:

HEAD DOWN  BREECH  TRANSVERSE  FACE/BROW

ANY CONGENITAL ANOMALIES OR DEFECTS?  YES  NO

EXPLAIN:

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

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? \_\_\_\_\_

AVERAGE NUMBER OF HOURS OF TV 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 PRODUCTS IN YOUR HOME?  YES  NO

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 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 \_\_\_\_\_  
 M  F  S  G

DEPRESSION  
 M  F  S  G

DIABETES  
 M  F  S  G

HEART DISEASE  
 M  F  S  G

LIVER DISEASE  
 M  F  S  G

HIGH CHOLESTEROL  
 M  F  S  G

HIGH BLOOD PRESSURE  
 M  F  S  G

LUNG PROBLEMS  
 M  F  S  G

SEIZURES  
 M  F  S  G

NECK PROBLEMS  
 M  F  S  G

BACK PROBLEMS  
 M  F  S  G

SCOLIOSIS  
 M  F  S  G

OSTEOARTHRITIS  
 M  F  S  G

RHEUMATOID ARTHRITIS  
 M  F  S  G

AUTOIMMUNE DISEASES  
 M  F  S  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"/> TICS OR REPETITIVE BEHAVIORS |
| <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          |
| <input type="checkbox"/> SEIZURES              | <input type="checkbox"/> SENSORY/SPECTRUM             |
| <input type="checkbox"/> ADD/ADHD              | <input type="checkbox"/> FOCUS/MEMORY ISSUES          |
| <input type="checkbox"/> JAUNDICE              | <input type="checkbox"/> ECZEMA                       |
| <input type="checkbox"/> ANXIETY/STRESS        | <input type="checkbox"/> SPEECH ISSUES                |
| <input type="checkbox"/> FAILURE TO THRIVE     | <input type="checkbox"/> DEPRESSION                   |
| <input type="checkbox"/> IMMUNE DEFICIENCY     | <input type="checkbox"/> KIDNEY ISSUES                |
| <input type="checkbox"/> VISION/HEARING ISSUES | <input type="checkbox"/> DIABETES MELLITUS TYPE _____ |
| <input type="checkbox"/> KNOCK KNEE            | <input type="checkbox"/> LOW ENERGY & FATIGUE         |
| <input type="checkbox"/> SCOLIOSIS             |   |

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. \_\_\_\_\_

*COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE*

CHECK MET OR NOT MET; IF DELAYED, PLEASE SPECIFY BY HOW MUCH

| AGE       | MILESTONE   | MET | NOT MET | DELAYED |
|-----------|---|-----|---------|---------|
| 1 MONTH   | FISTS CLENCH  |     |         |         |
| 2 MONTHS  | SMILES<br>COOS<br>HANDS OPEN  |     |         |         |
| 3 MONTHS  | HEAD CONTROL<br>OPENS MOUTH   |     |         |         |
| 4 MONTHS  | LAUGHS<br>PUSHES UP   |     |         |         |
| 5 MONTHS  | ROLLS BACK TO STOMACH   |     |         |         |
| 6 MONTHS  | SITS ALONE IN TRIPOD<br>REACHES<br>1 SYLLABLE WORD "DA"   |     |         |         |
| 8 MONTHS  | SITS ALONE<br>PINCHER GRIP<br>2 SYLLABLE WORD "DADA"  |     |         |         |
| 10 MONTHS | PULLS UP TO STAND<br>POINTS   |     |         |         |
| 11 MONTHS | CRUISING  |     |         |         |
| 12 MONTHS | STANDS ALONE<br>WALKS WITH SUPPORT<br>HOLDS CUP<br>KNOWS 2 WORDS  |     |         |         |
| 15 MONTHS | WALKS ALONE<br>CRAWLS UPSTAIRS<br>NAMES OBJECTS<br>MARKS WITH PENCIL<br>SAYS 4-5 WORDS<br>INDICATES WANTS |     |         |         |
| 18 MONTHS | RUNS<br>POINTS TO BODY PART<br>PARTIALLY FEEDS SELF   |     |         |         |

**NOTICE OF PRIVACY POLICY**

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

**To receive text appointment reminders, initial here \_\_\_\_\_**

*I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE:

**FINANCIAL POLICY AND AUTHORIZATION FOR CARE OF A MINOR**

*I hereby authorize the doctors in this chiropractic office to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.*

***Please read each statement and initial.***

- I understand that I am personally financially responsible for all services rendered to me or my child. \_\_\_\_\_
- I agree that all fees will be paid at the time of service unless arrangements have been made in advance with Ballard Family Chiropractic. \_\_\_\_\_
- I understand if I carry a balance, a card must be kept on file with an authorization for a monthly payment as agreed upon with Ballard Family Chiropractic. \_\_\_\_\_
- I understand if my balance exceeds \$500 care may be suspended until financial arrangements have been made. \_\_\_\_\_
- Ballard Family Chiropractic has a \$25 fee for no show appointments to be applied at the discretion of the staff if I miss appointments without appropriate notice or cancellation. \_\_\_\_\_

**To receive text appointment reminders, initial here \_\_\_\_\_**

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:

DATE: