

Child Member Health Record

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

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:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH:	

VACCINATIONS/MEDICATIONS

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 & # OF DOES CHILD HAS TAKEN:

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: <input type="checkbox"/> WELLNESS <input type="checkbox"/> CONDITION
IF CONDITION, 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 PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
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"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

Good Vibrations Family Chiropractic

4060 Adams Avenue
San Diego, CA 92116

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE

PRENATAL HISTORY

DURING PREGNANCY DID YOU USE:
 DRUGS/MEDICATIONS TOBACCO/ALCOHOL
 IF YES, PLEASE EXPLAIN:

LOCATION OF BIRTH:
 HOME BIRTHING CENTER HOSPITAL

DESCRIBE YOUR DELIVERY:
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY PREMATURE DELIVERY
 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:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?
 YES NO
 PLEASE EXPLAIN:

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES: AT 1 MIN _____/10 AT 5 MIN _____/10

ULTRASOUND DURING PREGNANCY? YES NO NUMBER: _____

DID YOU BREASTFEED THE BABY? YES NO
 IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY? YES NO
 IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?
 YES NO

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? YES NO
 PLEASE EXPLAIN:

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
 PLEASE EXPLAIN:

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

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child 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.*

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FREQUENT COLDS, COUGHS,
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> DIFFICULT WEIGHT GAIN	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> COLIC	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SLEEPING DIFFICULTIES