

Child Member Health Record

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	POSTAL CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
MHSC REGISTRATION No:	
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	PROV/POSTAL 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 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"/> WEBSITE <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"/> SPECIFIC CONCERN
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:

COMPLETE THIS PAGE FOR CHILDREN 9-13 YEARS OF AGE

CHILD'S CURRENT HEALTH

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT DISLOCATION? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER BEEN HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER HAD SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.) <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE LIST:
PLEASE RATE YOUR CHILD'S STRESS LEVELS ON A SCALE OF 1-10 (10=HIGH) SCHOOL: 1 2 3 4 5 6 7 8 9 10 PERSONAL: 1 2 3 4 5 6 7 8 9 10 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 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

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIFFICULTY/PAINFUL/IRREGULAR PERIODS	<input type="checkbox"/> NECK STIFFNESS/PAIN
<input type="checkbox"/> BACK PAIN/STIFFNESS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SHOULDERS/ELBOW, WRIST PAIN
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> HIPS, KNEES, ANKLES	<input type="checkbox"/> STRESS
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS

NUTRITION

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD HAVE FOOD ALLERGIES? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURRING SKIN RASHES? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD ELIMINATE STOOLS EACH DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?
WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?
WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?
WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?
HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?

"It is easier to build strong children than repair broken men."

AUTHORIZATION FOR CARE OF A MINOR

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I authorize the use of this signature to allow the insurance companies to pay Roblin Family Chiropractic Centre directly any amounts payable as my assignment of benefits.

I authorize the use of this signature on any insurance submissions.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:

DATE:

