Vitality Chiropractic and Family Wellness

Children's Health History Form

Today's Date_____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____ City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A

Name _____

Home phone (_____) _____

Home phone (_____) _____

Employer _____

E-mail _____

Parent B

Name _____

Home phone (_____) _____

Home phone (_____) _____

Employer _____

E-mail _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Vitality Chiropractic and Family Wellness can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____ Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

Any difficulty breast feeding? _____
_____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.

If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT	_____	❑ MMR	_____	❑ Other	_____
❑ Polio	_____	❑ Chicken Pox	_____		
❑ Hepatitis	_____	❑ Flu	_____		

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:

❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Vitality Chiropractic and Family Wellness

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

_____

FINANCES

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

INSURANCE INFORMATION

Vitality Chiropractic and Family Wellness is currently un-enrolled with insurance companies. However, the office is in the process of enrollment. For this reason, our fees have been established to be comparative to most co-pays, and allow everyone to receive chiropractic care. Super bills may be requested to submit to personal insurance companies.

Please indicate below the type and name of your Insurance**

If you have coverage, our staff will need a copy of your insurance card.

Insurance type: ❑ Medicare ❑ Auto Accident ❑ Other (e.g., Aetna, Cigna, GIC, etc.)

Insurance name:_____

Policy Holder: _____

Is this an Auto Accident Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Has your child been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other _____

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy

❑ Other (details)_____

PLEASE READ AND SIGN BELOW

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Katie Chenkus and/or Dr. Sherri Raley permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature_____ Today's Date_____

Signature of Parent (for minor):_____ Today's Date_____

Cancellation/ Broken Appointment Policy

Our commitment to your great chiropractic care begins with a defined schedule in which we have allotted specific amounts of time for you and other patient abased on your specific needs. With said, we understand that "life" happens and results in needed changes to our day to day schedule that may prevent us from keeping an appointment. We respectfully request at least **24 hour advanced notice** if you need to cancel an appointment. Giving us as much notice as possible ensures that someone else is able to take advantage of the time that was allotted to you.

An appointment that is cancelled with less than 24 hours' notice or an appointment that is not canceled at all in which the patient fails to appear to is considered a broken appointment. Broken appointments delay the success of your treatment and the treatment of other patients. Therefore, any broken appointments will result in a **$25.00 office fee**.

Thank you in advanced for your compliance with out cancellation and broken appointment policies. Please know that all policies are in place to ensure a great chiropractic experience for you and your family. Again, we look forward to serving your every chiropractic need!

Please initial below that you read and understand the cancellation and broken appointment policy.

Initial Here: _____