

# CLEAR CHOICE CHIROPRACTIC 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	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Home phone (_____) _____	Home phone (_____) _____
Employer _____	Employer _____
E-mail _____	E-mail _____

Whom may we thank for referring you to our office? \_\_\_\_\_

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Clear Choice Chiropractic 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  Exercise/Sports  Walking  
 Playing  Sleep  Attention/Focus  
 Communication  Eating  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 \_\_\_\_\_

# HEALTH, WELLNESS AND CHIROPRACTIC CARE

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? \_\_\_\_\_

## 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:

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> DPT _____       | <input type="checkbox"/> MMR _____         | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Polio _____     | <input type="checkbox"/> Chicken Pox _____ |                                      |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> 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:

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Academic pressure | <input type="checkbox"/> Loss of a loved one | <input type="checkbox"/> Bullying      | <input type="checkbox"/> Relocation  |
| <input type="checkbox"/> Lifestyle change  | <input type="checkbox"/> Parents' divorce    | <input type="checkbox"/> Loss of a pet | <input type="checkbox"/> 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?

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

Reason \_\_\_\_\_

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## 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.

Please indicate your method of payment.  Cash  Check  Credit Card

## INSURANCE INFORMATION

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. Please obtain an **Insurance Verification Form** from our staff. It is your responsibility to contact your insurance company to determine the amount and extent of coverage. **Until the Insurance Verification Form is complete and returned to us, we are unable to submit any insurance forms for you and your account will be administered on a cash basis.**

**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**

1. I have been informed that a copy of Clear Choice Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on the website at [www.clearchoicechiropractic.com](http://www.clearchoicechiropractic.com)
2. I consent to receive communication from Clear Choice Chiropractic via email, postal mail, text and telephone messaging in connection with my care.  Yes  No If I should withdraw my consent, I will notify the office in writing.
3. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to Clear Choice Chiropractic.  Yes  No If I should withdraw my consent, I will notify the office in writing.
4. I clearly understand and agree that all services rendered 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 that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.
5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

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

Child's Name: (Printed) \_\_\_\_\_

Parent or Legal Guardian's Name: (Printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

***Thank you for choosing Clear Choice Chiropractic.***

***We look forward to helping you.***