

Child Health Form

To be filled out by parent or guardian Please print clearly and fill in completely

Print Child's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Check: male\_\_\_\_ female\_\_\_\_

Health History:

Give reason for seeking chiropractic care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any health problems, including how long child has had them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child under the care of any other doctor? Yes\_\_\_\_\_ No\_\_\_\_\_

If Yes, please list the doctors your child is seeing, the conditions being treated for, and any

progress.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any x-rays child has had in the past 2 years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractic History:

Has child been to a Chiropractor before? Yes\_\_\_\_ No\_\_\_\_ If yes Doctor's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason for care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of any chiropractic x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long was child under care? \_\_\_\_\_\_\_\_\_\_\_

Are other family members under chiropractic care? - Yes No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any other information you feel would assist us in the care of you

child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Birth**

Hospital/ Birthing Center: \_\_\_\_ Home\_\_\_\_\_ Medical\_\_\_\_\_ Midwife Duration of Gestation: \_\_\_\_\_\_\_ weeks

Was the birth assisted? \_\_\_ Yes \_\_\_No If yes, how? \_\_\_ Forceps \_\_\_ Vacuum Extraction\_\_\_ C-section\_\_\_\_ Induced Labor

Where medications given to the mother at birth? \_\_\_\_ Yes \_\_\_No If yes, what? \_\_\_\_\_\_\_\_\_\_ Duration of Birth: \_\_\_\_\_\_\_\_

Was the delivery normal? \_\_\_ Yes \_\_\_No If no, what complications were there at birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APGAR at Birth\_\_\_\_\_\_ APGAR after 5 minutes\_\_\_\_\_\_ Birth Weight\_\_\_\_\_\_\_ Birth Length\_\_\_\_\_\_\_\_

**Growth and Development**

 Was the infant alert &responsive within 12 hours of delivery? \_\_\_Yes \_\_\_No If no, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did the child: Respond to sound?\_\_\_\_ Follow an object?\_\_\_\_\_ Hold up head?\_\_\_\_\_ Vocalize?\_\_\_\_\_ Sit alone?\_\_\_\_\_ Teeth?\_\_\_\_\_ Crawl?\_\_\_\_\_\_ Walk?\_\_\_\_\_ Are his/her sleep patterns normal? \_\_\_Yes \_\_\_No

Describe any health problems that exist on the mother’s side of the family? (e.g. cancer, diabetes etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The father’s side? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do the child’s siblings have any health problems? \_\_\_\_Yes \_\_\_\_No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The following information is very important because many of the problems that chiropractors work with are caused by stressors.*

**Chemical Stressors**

During Pregnancy, did the mother: 1. Smoke? \_\_\_Yes \_\_\_No 2. Drink alcohol? \_\_\_Yes \_\_\_No 3. Take supplements/vitamins \_\_\_Yes \_\_\_No 4. Take Drugs? \_\_\_Yes \_\_\_No If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. Become ill? If so how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. Receive ultrasounds? \_\_\_Yes \_\_\_No If yes, how many? \_\_\_ 7. Receive invasive procedures (ie. Amniocentesis/ vitamins? \_\_\_Yes \_\_\_No 8. Was your child breast fed? \_\_\_Yes \_\_\_No If yes, for how long? \_\_\_ weeks months years At what **age** was: Formula introduced? \_\_\_ Brand? \_\_\_ Cow’s milk? \_\_\_ yrs Solid foods? \_\_\_ yrs Did your child receive vaccinations? \_\_\_Yes \_\_\_No If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did your child react to them? \_\_Yes \_\_\_No Has your child had antibiotics? \_\_\_Yes \_\_\_No If yes, how many courses has the child had so far & why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets at home? \_\_\_Yes \_\_\_No Any smokers? \_\_\_Yes \_\_\_No If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological Stressors**

Any difficulties with lactation? \_\_\_Yes \_\_\_No Any problems bonding? \_\_\_Yes \_\_\_No Does your child seem normal to you? \_\_\_Yes \_\_\_No Does your child have any noted behavior problems? \_\_\_Yes \_\_\_No If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your child have difficulties sleeping (e.g. night terrors, sleep walking, ect.)? \_\_\_Yes \_\_\_No If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your child attend daycare? \_\_\_Yes \_\_\_No From what age? \_\_\_\_\_\_\_ yrs

**Traumatic Stressors**

Any evidence of trauma during birth?\_\_\_\_ bruises \_\_\_\_\_ odd shaped head \_\_\_\_\_stuck in birth canal \_\_\_\_ Fast and/or excessively long birth \_\_\_\_ Respiratory depression \_\_\_\_ cord around the neck Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any falls/accidents during pregnancy? \_\_\_\_\_Yes \_\_\_\_\_No Has the child had a major fall since birth?\_\_\_\_\_Yes \_\_\_\_No

Any hospitalizations?\_\_\_\_Yes\_\_\_\_No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child play sports? \_\_\_\_ Yes \_\_\_\_\_No Does your child wear a backpack? \_\_\_\_\_\_lbs

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD

 NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE DR. KRISTIN HEINTZ AND ANY AND ALL RENEW HEALTH FAMILY

CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES,

RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND

PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND

AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY

AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR

ALTERED, I WILL IMMEDIATELY NOTIFY RENEW HEALTH FAMILY CHIROPRACTIC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GUARDIAN SIGNATURE DATE

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WITNESS SIGNATURE GUARDIAN’S RELATIONSHIP TO MINOR CHILD