ABOUT THE PATIENT 1-13 yoa

Simply Health Chiropractic E5028 US Highway 14, Spring Green, WI 53588

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Parent Home Phone _____ Cell Phone _____ Gender ❑ M ❑ F

Parents' Names _____ Siblings Names and Ages _____

Parent's e-Mail Address _____ Best time to contact you? _____

Preferred way of receiving contact: ❑Phone Call ❑Email ❑Text ❑Other _____

Has your child been to a chiropractor before? ▫ No ▫ Yes If yes, Was it an Optimal Health and Wellness Chiropractor? ▫ No ▫ Yes

Name of Medical Doctor(s)_____

- I authorize the doctor or her staff to render care as deemed appropriate for my child.
- I authorize Simply Health Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the parent?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Play ❑ Daily Routine ❑ Sitting ❑ Eating

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

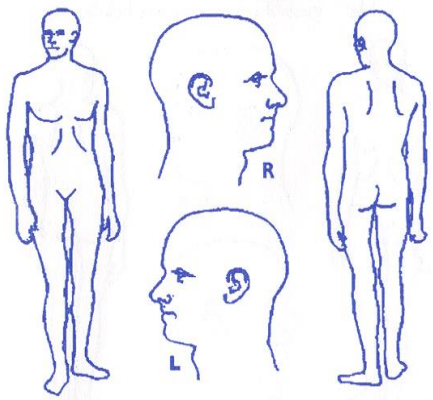
10. Results: _____

NOTES: _____

_____

_____

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Simply Health Chiropractic E5028 US Highway 14, Spring Green, WI 53588

Patient Name_____ *Mark the conditions that apply to your child.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Ear Infections
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

Pregnancy and Birth History: Physical, Chemical and Emotional Stress

Gestational Duration:_____ weeks **Any Traumas or Falls during Pregnancy?** _____

Any Ultrasounds or Radiation during pregnancy? Yes / No How many / What reasons? _____

Any Invasive Procedures (eg Amniocentesis, CVS)? Yes / No

During Pregnancy, did the mother (check all that apply): ❑Smoke ❑Drink Alcohol ❑Take Prescription Medications ❑Recreational Drugs ❑Fall Ill during Pregnancy

During Pregnancy, did mother take supplements? Yes / No List all: _____

Mother's level of mental-emotional stress during pregnancy 1-10 (1=low, 10=high): _____

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home

Birthing assistants? ❑Midwife ❑Doula ❑Obstetrician ❑Other **Was labor induced?** Yes / No

Duration of Labor? _____ Duration of active (pushing stage) labor? _____

Were any medications received during labor? Yes / No List medications: _____

Was there any assistance needed during birth? ❑Forceps ❑Cesarean ❑Vacuum extraction ❑Assisted traction/Head turning

Was delivery considered normal? Yes / No **If no, explain complications:** _____

Was there any evidence of birth trauma to the infant? Check all that apply:

❑Bruising ❑Odd shaped head ❑Stuck in birth canal

❑Fast or excessively long birth ❑Respiratory depression ❑Cord around neck

Was your child subjected to any of the following? Check all that apply:

❑Silver nitrate drops in eyes ❑Incubation How long? _____ ❑Vitamin K shot

❑Hepatitis shot ❑Separation from you How long? _____

Did your child spend any time in intensive care? Yes / No **If yes, how long?** _____

APGAR score at birth? _____ **APGAR score at 5 minutes?** _____

Birth weight? _____ **Birth length?** _____

Is there anything else you want us to know about the birth? _____

_____

_____

STRESSORS 1-13 yoa

Simply Health Chiropractic E5028 US Highway 14, Spring Green, WI 53588

Because accumulation of stress affects our health and ability to heal, please answer the following questions about your child's possible childhood stressors in each category:

1. Physical stress

Does your child have a preferred sleeping position? **Yes No.** Did/does your child prefer one-sided breast-feeding position? **Yes No**

Did your child spit up after feeding? **Yes No** Any falls or injuries downstairs, bicycle, etc? **Yes No**

Does your child ever bang his/her head repeatedly? **Yes No** Any traumas resulting in bruising, fractures or stiches? **Yes No**

Any hospitalizations or surgeries? **Yes No** Does your child play sports? **Yes No**

School backpack used? **Yes No** Weight of backpack? _____ **lbs**

Approximate hours spent at play per week? _____ Approximate hours spent at computer/TV/video games per week? _____

Does your child wear glasses or contacts? **Yes No** Does your child have difficulty reading the board? **Yes No**

Does your child have difficulty with coordination? **Yes No**

Please elaborate on questions you answered "Yes" to in the above section. _____

_____

_____

List any accidents and/or injuries: auto, sports, or other (especially those related to your child's present problems)

_____

2. Bio-Chemical Stress

Did you child breastfeed? **Yes No** **If yes, for how long?** _____

At what age was…. formula introduced (and what brand)? _____ Cow's milk introduced? _____ Solid food introduced? _____

Does your child have food allergies? Yes No If yes, please explain: _____

Does your child have a bowel movement daily? Yes No If no, please explain:_____

Does your child have regular or occasional skin rashes? Yes No If yes, please explain: _____

What vaccinations were given and at what age? _____

_____

Were there any negative reactions? **Yes No** If yes, please explain: _____

Regarding reactions, were there any (circle all that apply): Fever Irritability Bowel Disturbances Drowsiness Unconsolable crying Arching of body Feeding disturbances Other: _____

History of Antibiotics: Yes No If yes, how many courses of antibiotics in your child's lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL Medications your child currently takes or has taken in the past 6 months (name, dosage, why they take/took it):

_____

Please list all nutritional supplements, vitamins and homeopathic remedies your child presently takes: _____

_____

What is your child's favorite food? _____ **What does your child regularly drink?** _____

How often does your child consume sugar? _____

3. Emotional Stress

Did mother have trouble breast feeding? **Yes No** Did mother and baby have difficulty bonding? **Yes No**

Did mother experience any post-partum depression? **Yes No**

Any night terrors/sleep walking/difficult sleep? **Yes No** Is their sleep pattern normal? **Yes No**

Quality of sleep: **Good Fair Poor** Number of hours of sleep: _____

Any behavioral problems? **Yes No** Do you feel your child's social and emotional development is normal his/her for age? **Yes No**

Does your child attend daycare? **Yes No** If yes, from what age? _____

Please elaborate on anything not covered regarding your child's emotional stress: _____

_____

GROWTH AND DEVELOPMENT HISTORY

SHC E5028 US Highway 14, Spring Green, WI 53588

1. Was your child alert and responsive within 12 hours of delivery? Yes No If no, please explain: _____

_____

At what age did your child:

Respond to Sound:	_____	Sit alone:	_____
Follow an Object:	_____	Teethe:	_____
Hold head up:	_____	Crawl:	_____
Vocalize:	_____	Walk:	_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

PARENTAL GENERAL HEALTH ASSESSMENT OF CHILD

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your child's:

Eating Habits: _____ Play Habits: _____ Sleep: _____ General Health: _____ Emotional Regulation: _____

How do you grade your child's Physical Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

How do you grade your child's Emotional / Mental Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

Is there anything else which may help us better understand your child which has not been discussed?

_____

_____

_____

Why are you here at this point in time and what are you hoping our office can do for your child?

_____

_____

_____

I consent to a professional and complete chiropractic examination and to any radiographic examination the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____