6769 Courtland Drive, Ste. 100
Rockford, MI 49341
616-863-9482

*Confidential Patient Health Record*

Date:________________ I.D.#____________

## PERSONAL HISTORY.

Name_______________________________________________ City: ___________________________________

Address: ________________________________________________ State:_____________ Zip: ______________

Birth Date:_________________Age:_____Sex: ☐ M ☐ F Social Security Number:.__________________________________

Parent/Guardian Name: ________________________________________________________________________

Parent/Guardian Home Phone:_____________________________Cell Phone:_______________________________________

Parent/Guardian Email: ______________________________ Whom may we thank for referring you to us?: ____________________

Name Of Emergency Contact:_________________________Relationship:_____________Phone Number:________________

## CURRENT HEALTH CONDITION

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain

What health challenge(s) is your child here for?_________________________________________________________

What do you feel is the cause of your child's problem?____________________________________________________

When did you first notice this sign of body dysfunction? _ /___/ ____ Please Explain:_________________________________

Are they in pain? ☐ Yes ☐ No Rate his/her pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did his/her pain/injury occur during: ☐Routine Activities ☐Sports/Play ☐Auto Accident ☐Other____________________

Has he/she seen anyone else for this condition? ☐Yes ☐No Who?___________________________________

Type of Treatment:_____________________________ Results:____________________________________________

Is their condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is their condition interfering with: ☐School ☐Sleep ☐Daily routine? If so, how?_________________________________

## HEALTH HISTORY

Is your child a: ☐ Birth child ☐ Adopted child **If your child was adopted please answer all information to the best of your ability*

Was this delivery: ☐ Vaginal Delivery ☐ C-Section

How long was labor and delivery?________________________________________________________________

Were forceps or vacuum extraction used?______________________________________________________________

Was/is your child breastfed? ☐Yes ☐No If so, for how long?__________________________________________________

At what age did your child crawl? ____________________ How long did they crawl for? ____________________________

Did/does your child like "tummy time?" ☐ Yes ☐ No

Did/do you choose to vaccinate your kids? ☐ Yes ☐ No

## HEALTH HISTORY CONT'D

Please Check and Describe:

Major Surgery/Operations/Hospitalizations: ☐Tubes in Ears ☐Broken Bones ☐Bone Fusions ☐Back surgery ☐Other

Describe: ______________________________________________

______________________________________________

Previous Chiropractic Care: ☐None ☐Doctor's Name & Approximate Date of Last Visit: ______________________

Please CIRCLE any & all of the following health challenges your child has suffered and/or continues to suffer from:

| | | | |
|---|---|---|---|
| Allergies | Irregular Sleep Patterns | Mood Swings | Congenital Heart Defect |
| Ear Infections | Anxiety | Infected/Sore throat | Laryngitis |
| Tonsillitis | Asthma | Reflux/Spitting up | Poor Appetite |
| Neck Pain | Upper Respiratory Infections | Frequent Cold/Congestion | ADD/ADHD |
| Psychiatric Problems | Night Terrors | Bed Wetting | Headaches |
| Ulcers/Colitis | Fainting/Seizures/Epilepsy | Sinus Problems | Chronic Diaper Rash |
| Colic | Difficulty Breathing | Diabetes | Bruising |
| Poor Digestion (constipation/diarrhea) | | Eczema/psoriasis/Other skin rashes | |

Is your child *currently* taking any prescription medication(s)? ☐ Yes ☐ No

If so, please list those medication(s) here: ______________________

Has your child taken any prescription medication(s) in the *past?* ☐ Yes ☐ No

If so, please list those medication(s) here: ______________________

Does your child take any supplements? ☐ Yes ☐ No

If so, please list those supplements here: ______________________

Does your child exercise regularly? ☐ Yes ☐ No

Please list anything that your child may be allergic to: ______________________

## Dr.'s Notes

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