CHILD HEALTH HISTORY FORM

Child's Name: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (_____)_____-_____ Mother/Father's Work Phone: (_____)_____-_____
Mother's Name: _____ Father's Name: _____
Sibling(s) Name(s) & Age(s) : _____
_____
Reason for consulting our office: _____
_____
Has your child been under chiropractic care before? Yes / No If Yes, with whom? _____
How long was care received? _____ Last Spinal Check-Up: _____

CIRCLE APPROPRIATELY

Birth Place: Home / Birth Center / Hospital Birth Type: Vaginal / C-Section
Procedures Used: Forceps / Vacuum Extraction Was delivery long? Yes / No
Was delivery difficult? Yes / No Was Labor Induced? Yes / No
Was the Mother given an Epidural? Yes / No ***OR*** Pain Medication? Yes / No
Was the baby breech / in utero constraint? Yes / No Was the baby breast fed? Yes / No
What sport(s) does / did your child participate in? None / Football / Gymnastics / Cheerleading / Karate / Baseball / Basketball / Dance / Other(s) : _____

According to the National Safety Council, approximately 54% of all infants fall head first from a high place (bed, changing table, etc) during the first year of life. Has this happened to your child? Yes / No Comments: _____
List any other falls or accidents: _____

Has your child suffered from any of the following:
Circle R if experienced within the last 6 months, Circle P if longer than 6 months ago

P / R Ear Infections	P / R Scoliosis	P / R Seizures
P / R Headaches	P / R Asthma	P / R Allergies
P / R Growing Pains	P / R Colic	P / R Digestive Problems
P / R Constipation	P / R Head Banging	P / R Bed Wetting
P / R Recurring Fevers	P / R Back Pain	P / R ADD/ADHD

Has your child ever been hospitalized? Yes / No If Yes, please describe: _____
_____

Has your child ever had surgery? Yes / No If Yes, please describe: _____
_____

CHILDHOOD DISEASES

Chicken Pox Yes / No Age:__ Rubella Yes / No Age:__ Rubeola Yes / No Age:__
Mumps Yes / No Age:__ Whooping Cough Yes / No Age:__ Other Yes / No Age:__

MEDICATION

How many rounds of antibiotics has your child taken in the past 6 months? _____
How many rounds of antibiotics has your child taken in their life? _____
Present prescription drugs: _____
Past prescription drugs: _____
Over-the-counter drugs taken in the past 6 months: _____

Is there anything else you are concerned about in regards to your child that you would like us to know about? _____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. My presence is / is not required for care to be rendered.

Name of Parent: _____ Date: ____/____/____
Signature of Parent: _____
Witness: _____

We are delighted that you have chosen to have your child's spine evaluated. Many types of stress (physical, chemical, and emotional) can interfere with your child's growing nervous system. Spinal health is an exciting new concept for many parents, so please feel free to ask questions. We are here to serve your family, please let us know how we can make your experience in our office better.

PAYMENT IS EXPECTED AT TIME SERVICE IS RENDERED

Name of person responsible for payment: _____
Are you insured? Yes / No Insurance Company: _____

Please present your insurance card to our staff so we may make a copy for our records.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office in relation to treatment provided for my above named child. I further agree if this account be placed in the hands of any attorney or collection agency for collections, I will be responsible for all reasonable collection, attorney and/or court fees. I hereby assign to this office, my rights to receive payments from negligent parties or from insurance companies. I hereby authorize the release of any medical or other information to process claims for payment. I hereby authorize and direct my attorney to pay directly to Total Health Chiropractic such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due in this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. Payments should be payable to and mailed to:

Total Health Chiropractic
3742 Tennessee Ave., Ste. 104 Chattanooga, TN 37409

Parent's Signature: _____ SS#: _____ Date: ____/____/____
Attorney's Signature: _____ Date: ____/____/____