IMPERIUM
HEALTH CENTER

Children's Health Record

Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Weight: _____ Height: _____ Gender: M / F

Parents Name's: _____

Parents Employer's: _____

Parents Email: _____ Parents Work Phone: _____

Whom may we thank for referring you to our office? _____

Reason for this Visit

Describe the purpose for this visit: _____
_____
_____

Is the purpose of this visit related to (Circle): Sports / Auto / A Fall / Home Injury / Chronic Discomfort/ Other
Please Explain: _____
_____
_____

When did this condition begin: _____
_____

Has this condition (Circle): Gotten Worse / Stayed Constant / Comes and Goes

Does this condition interfere with (Circle): Sleep / Daily Routine / Other Activities
Please Explain: _____
_____

Has this condition occurred before: Yes / No
Please Explain: _____
_____

Have you seen other doctors for this condition: Yes / No Dr.'s Name:_____
Type of Treatment: _____
Results: _____

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Mother's Pregnancy & Labor

During the pregnancy, did the mother:

Take any medication: Yes / No

Please Explain: _____

_____

Smoke or consume alcohol: Yes / No

Experience any illness: Yes / No

Approximately how long did labor last? _____ Hours

Was labor chemically induced? Yes / No

Was labor doctor assisted? Yes / No

Was a C-Section performed? Yes / No

Were forceps or vacuum extraction used? Yes / No

Did the delivery doctor pull or twist the baby during delivery? Yes / No

Was the delivery premature? Yes / No

If yes, at _____ month and _____ weight

Circle any of the following if the child experienced it immediately after birth:

Jaundice / Respiratory Problems / Feeding problems / Displaced or Broken Joints / Other

Health History

Please circle each of the diseases or condition that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

Vision Problems	Pink Eye	Headaches
Ear Problems	Sleeping Disorders	Tubes in Ears
Irritability	Attention Problems	Skin Problems
Frequent Colds	Allergies	Colic
Breathing Problems	Digestive Problems	Asthma
Hyperactivity	Constipation	Bed Wetting

Other _____

_____

_____

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Current Health Status

Is your child accident prone? Yes / No

Has your Child:

- Been hospitalized? Yes / No
- Had a severe fall? Yes / No
- Been in a car accident? Yes / No

Has your child ever taken antibiotics? Yes / No

If yes, please explain _____

_____

Is your child currently taking any medication? Yes / No

If yes, please explain _____

_____

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

What changes (if any) in your child's health or behavior would you like accomplished? _____

_____

_____

Goals for Care

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of the pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your child's care program. Please circle the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care	- Symptomatic relief of pain or discomfort
Corrective Care	- Correcting and relieving the cause of the problem as well as the symptoms
Comprehensive Care	- Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.
Dr.'s Choice of Care	- I want the doctor to select the type of care appropriate for my child.

Parent / Guardian's Signature: _____ Date: _____

Vaccinations

Have you chosen to vaccinate your child? Yes / No

If yes, circle all vaccinations your child has received:

DPT MMR Polio Chicken Pox Hepatitis

Other: _____

_____

_____

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Authorization to Care for a Minor Child

I hereby authorize the doctors in this chiropractic office, and whomever they may designate as their assistant to administer chiropractic care, to work with my child (name) _____ through the use of adjustments and procedures to the spine, as the doctor deems appropriate.

I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible payment. I agree that I am responsible for all incurred at this office. The doctor will not ne held responsible for any preexisting medical 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.

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that the doctor's office will prepare any necessary reports and forms to assist me in the 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.

Parent / Guardian's Name (print): _____

Parent / Guardian's Name (print): _____

Parent / Guardian's Signature Authorizing Care: _____ Date: _____