

WELCOME TO DYNAMIC FAMILY CHIROPRACTIC

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Child Health History Form

First Name _____ MI _____ Last _____ Birth Date ___/___/___ Age _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Parents Name _____ Home () _____ S.S. # _____ - _____ - _____
Male ___ Female ___ Number of Children _____ Who may we thank for referring you to our office? _____

Reason for consulting our office? _____

If your child has no symptoms or complaints, and is here for wellness services, please check ___; others need to briefly describe the chief area of complaints, including the effects it has on the child.

If he/she is experiencing pain, is it: Sharp ___ Dull ___ Comes and Goes ___ Travels ___ Constant ___

Since the problem started, is it: About the same ___ Getting Better ___ Getting Worse ___

What makes it worse? _____

Other doctors seen for this problem:

Chiropractor: _____

Medical Doctor: _____

Other: _____

List Medications the child is taking or surgeries the child has had:

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most of the time the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was mom on any medications, prescription or over-the-counter? Yes ___ No ___

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? Yes ___ No ___ Who? _____

Was baby ever in the Breech position? Yes ___ No ___

How many ultrasounds were performed? _____

Birth and Delivery:

Where was baby born? Home ___ Hospital ___ Birthing Center ___ Other: _____

Was the delivery: Vaginal ___ C-Section ___ Were any devices used? Forceps ___ Vacuum ___

How long was the labor? _____ How long was the delivery? _____

Was oxytocin/pitocin used? Yes ___ No ___ Was an epidural administered? Yes ___ No ___

Infancy:

Was infant vaccinated? Yes ___ No ___

Was there any prolonged use of medicines or an inhaler? Yes ___ No ___ If yes, which _____

Did the infant suffer any traumas such as a serious falls or car accidents? Yes ___ No ___

Has the infant been under regular chiropractic care? Yes ___ No ___

Childhood Years:

Did the child have any childhood illnesses? Yes ___ No ___

Has the child had any surgeries? Yes ___ No ___

Has the child been involved in any car accidents? Yes ___ No ___

Does the child play in any youth sports? Yes ___ No ___

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor child:

I, _____, being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

I have read and understand the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Signature

Date