Your Child's Health & History

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Social Security # _____-____-_____

Parent/Guardian: _____

Parent's Date of Birth:_____ Social Security # _____-____-_____

How did you hear about our office? _____

What is your child's major complaint?_____

How long have they had this condition?_____

INSURANCE INFO

Insurance Name:_____

Policy #:_____ Group #:_____

Policy Holder Name:_____ Date of Birth:___-___-_____ SS# _____-____-_____

Address of policy holder (if different from patient):_____

WHY THIS FORM IS IMPORTANT

As a full-spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are first, to address the issues that brought you to this office, and secondly, to offer you the opportunity of improved health and wellness service in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better access the challenges to your health potential. Research is documenting that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Therefore, please answer the following questions to the best of your ability.

PLEASE CIRCLE THE APPROPRIATE RESPONSE(S):

1. Was your child born vaginally or by cesarean section?
2. Was his/her birth a natural or medicated birth (Epidural, Pitocin, antibiotics)?
3. Birth place: Home Hospital Birth Center
4. Procedures: Forceps Vacuum Extraction

5. Was the mother under regular Chiropractic care? Yes No

6. Did the mother take vitamins during gestation? Yes No

7. What was the mother's health condition during pregnancy? Excellent Good Poor

8. Did the mother consume any over-the-counter, prescription, or other medications during pregnancy? Yes No

If yes, please list: _____

9. Please briefly describe your child's health history to this point. Any events that stick in your mind are relevant.

_____
_____
_____
_____

10. According to the National Safety Council, approximately 50% of infants fall <u>head first</u> from a high place (bed, changing table, etc) during the first year of life. Has this happened to your child? N Y

11. How many prescriptions of antibiotics has your child taken?
During past 6 months? _____ Total during lifetime? _____

12. How many other prescriptions or over-the-counter (cough syrup, aspirin, inhalers) has your child taken?
During past 6 months? _____ Total during lifetime? _____

13. Which contact sports does your child participate in?
Soccer ___ Football ___ Karate ___ Hockey ___ Basketball ___ Wrestling ___

14. Which of the following conditions has your child suffered from:

Ear infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma	Allergies	Emotional Trauma	Recurring Fevers	Colic
Temper Tantrums	Bed Wetting	Car Accident	Surgeries	ADHD
Growing or Back Pain		Digestive Problems		

15. How can we specifically help your son/daughter?

_____
_____
_____
_____

I, the undersigned certify that I (or my dependent) assign directly to Dr. Lajiness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Parent/Guardian Signature_____ Date _____ LSC