



**FAMILY ROOTS CHIROPRACTIC
CHILDREN'S HEALTH HISTORY FORM**

Today's _____
Date _____

ABOUT THE CHILD

Name _____ Age _____
Date of Birth _____

Gender M F

Height _____ Weight _____

Home Address _____ City _____ State _____ Zip _____

Names and Ages of Siblings _____

Parent A	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Home phone (_____) _____	Home phone (_____) _____
Employer _____	Employer _____
E-mail _____	E-mail _____

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

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Family Roots Chiropractic can address for your child? _____

Related to: Sports Auto Fall Chronic Home Injury Other _____

Please describe how these concerns are affecting your child's quality of life. _____

- Check all that apply
- | | | |
|--|--|--|
| <input type="checkbox"/> School | <input type="checkbox"/> Exercise/Sports | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Playing | <input type="checkbox"/> Sleep | <input type="checkbox"/> Attention/Focus |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Eating | <input type="checkbox"/> Daily Routine |

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

- Check all that apply
- Symptomatic relief of pain or discomfort
 - Correction of the cause of the problem as well as relief of symptoms
 - Prevention of future problems
 - Healthier spine and nerve system
 - Optimal health on all levels
 - OTHER _____

**The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.**

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:

- Experience any significant illnesses, difficulties, or trauma? _____
- Take any drugs/medications? _____
- Smoke or consume alcohol

- Home birth
- Hospital birth
- Vaginal
- Water birth
- Caesarean

Was the delivery premature? No Yes Weeks _____ Weight _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? No Yes _____

Was it determined that the child was breech or otherwise malpositioned? No Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

- Epidural
- Forceps
- Vacuum
- Medications _____
- Pitocin
- Episiotomy
- Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

- Jaundice
- Respiratory problems
- Broken bones _____
- Feeding problem
- Displaced joints
- Other conditions _____

APGAR Score _____

Was the baby breastfed? No Yes For how long? _____

Who is your primary physician? _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? No Yes.

If yes, please check all vaccinations the child has received and at what age they were administered:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> DPT _____ | <input type="checkbox"/> MMR _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Chicken Pox _____ | |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Flu _____ | |

Please describe any and all reactions to vaccine(s) _____

Please check all that apply and give any necessary details:

- Child exposed to second hand smoke.
- Has taken antibiotics. Explain _____
- Currently taking medication. Explain _____
- Currently taking supplements. Explain _____
- Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: Sports Auto Fall Chronic Home Injury Other

Please check all that apply to your child and give any necessary details:

- Uncoordinated/Accident prone
- Has been hospitalized. _____
- Had a severe trauma. _____
- Been in an automobile accident. _____
- Has fractured a bone or dislocated a joint. _____
- Has/had a chronic illness. _____
- Has had surgery. _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Academic pressure | <input type="checkbox"/> Loss of a loved one | <input type="checkbox"/> Bullying | <input type="checkbox"/> Relocation |
| <input type="checkbox"/> Lifestyle change | <input type="checkbox"/> Parents' divorce | <input type="checkbox"/> Loss of a pet | <input type="checkbox"/> New sibling |

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

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? Y N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply Medical Physician Naturopath Acupuncturist Homeopath
 Massage Therapist Psychotherapist Energy Healer Other

Reason _____

Finances

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. Cash Check Credit Card

First Visit Fees: Comprehensive Exam: \$97

PLEASE READ AND SIGN

1. I have been informed that a copy of Family Roots Chiropractic's "Notice of Privacy Practices for Protected Health Information (*HIPAA*)" brochure is available for my review.
2. I consent to receive communication from Family Roots Chiropractic via email, postal mail, text and telephone messaging in connection with my care. Yes No If I should withdraw my consent, I will notify the office in writing.
3. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to Family Roots Chiropractic. Yes No If I should withdraw my consent, I will notify the office in writing.
4. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically 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.
5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in 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.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Ashley Rath permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed) _____

Parent or Legal Guardian's Name: (Printed) _____

Signature _____ Date: _____

Thank you for choosing Family Roots Chiropractic.

We look forward to helping you.