Bluewater Chiropractic Wellness Center
4400 Hwy 20 E Ste 207
Niceville, FL 32578
(850) 897-1177

CHILDREN'S HEALTH RECORD

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Parent's Name ____________ **Today's Date** ____________

About your child:

Your Child's Last Name ____________

Your Child's First Name ____________ **Birth Date (MM/DD/YYYY)** ____________ **Age & Gender** ____________

Address ____________ **Height** ____________

City ____________ **State/Province** ____________ **ZIP/Postal Code** ____________ **Home Phone** ____________

Parent's Employer ____________ **Work Phone** ____________ **Cell Phone** ____________ **E-mail Address** ____________

Payment Method ____________ **Credit Card Details** ____________ **Exp. Date** ____________

Insurance Carrier ____________ **Policy Number** ____________ **Policy Group Number** ____________

Policy Holder's Name ____________ **Primary Care Provider's Name** ____________ **Policy Holder's Social Security#** ____________

Mother's pregnancy & labor:

During the pregnancy did the mother take any medication? ☐ Yes ☐ No

Explain ____________

Smoke or consume alcohol? ☐ Yes ☐ No

Explain ____________

Experience any illness? ☐ Yes ☐ No

Explain ____________

Approximately how long did the labor last? ____________ **Hours**

Was labor chemically induced? ☐ Yes ☐ No

Was labor doctor assisted? ☐ Yes ☐ No

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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___________weight.

Check any of the following if the child experiences it.

Jaundice ☐ Yes ☐ No

Feeding problems ☐ Yes ☐ No

Respiratory problems ☐ Yes ☐ No

Displaced or broken Joints ☐ Yes ☐ No

Other condition(s)

____

Explain

Your child's 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 any antibiotics? ☐ Yes ☐ No

____

If yes explain

Is your child currently taking any medication? ☐ Yes ☐ No

____

If yes explain

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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?

Explain

Reason for today's visit:

Describe the purpose of the visit

Is the purpose of this appointment related to?

Sports: □ Yes □ No
Auto: □ Yes □ No
Fall: □ Yes □ No
Home injury: □ Yes □ No
Chronic discomfort: □ Yes □ No
Other □ Yes □ No

Explain

When did this condition begin?

Explain

Has this condition gotten worse? □ Yes □ No
Stayed constant? □ Yes □ No
Comes and goes? □ Yes □ No
Does the condition interfere with Sleep? □ Yes □ No
Daily routine? □ Yes □ No
Other activities? □ Yes □ No

Explain

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Has this condition occurred before? ☐ Yes ☐ No

____
Explain

Have you seen other doctor's about this condition? ☐ Yes ☐ No

Dr.'s Name(s) ____

Type of treatment____

Results____

Your Child's health history:

Please check each of the conditions that your 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**
☐ **Headache**
☐ **Ear problems**
☐ **Sleeping disorder**
☐ **Tubes in the ear**
☐ **Irritability**
☐ **Attention problems**
☐ **Skin problems**
☐ **Frequent colds**
☐ **Allergies**
☐ **Colic**
☐ **Breathing problems**
☐ **Digestive problems**
☐ **Asthma**
☐ **Hyperactivity**
☐ **Constipation**
☐ **Bed Wetting**
☐ **Other**

____
Explain

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Goals for my child's care:

Children see chiropractor's for a variety of reasons. Some go for the relief of pain, some to correct the cause of 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 chiropractic care program. Please check 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 or 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.**

☐ **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" please check all the vaccines the child has received.

☐ **DPT** ☐ **MMR** ☐ **Polio** ☐ **Chickenpox** ☐ **Hepatitis**
Other____

____
Describe any and all reactions to vaccine(s)

Authorization to care for a minor child

I hereby authorize the doctors in the 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.

__________________________ __________________________
Patient Name (Print) ***Parent or Legal Guardian's Name (Print)***

______________________________ ______________
Parent/Guardian's Signature Authorizing Care ***Date (MM/DD/YYYY)***