Welcome

Vitality CHIROPRACTIC
Drs David and Grace Basista

CHILDREN'S HEALTH RECORD

Name: _____ What do you prefer to be called? _____

Hm Phone: _____ Wk _____ Cell _____

Address: _____ City:_____ St: _____ Zip:_____

Mother's Name _____ Father's Name:_____

Date of Birth: _____ Age_____ Parent's E-mail Address _____

Parent's Occupation: _____ Employer:_____

Whom may we thank for referring you? _____

Have you had Chiropractic care before? ❑Yes ❑No Date: _____

What Brought You Into This Office? Specific complaint ❑ Wellness check up ❑

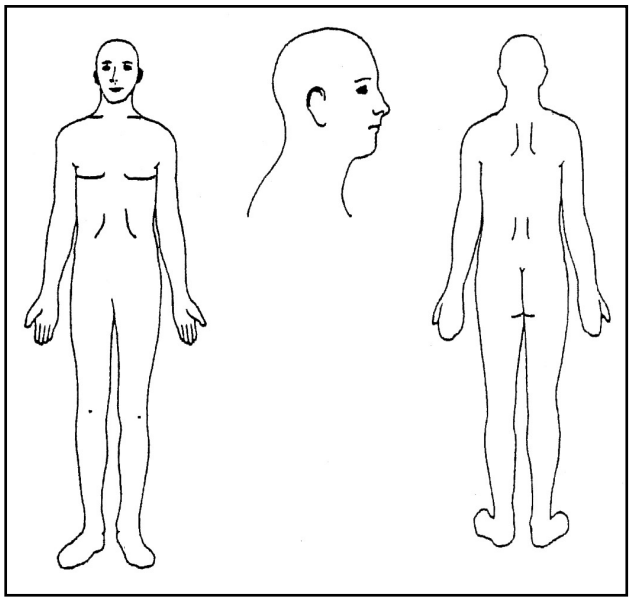
*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Current Health Concerns

Please list your health concerns according to their severity	Rate severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE LOCATED;

P = SHARP PAIN **A** = ACHE
T = TIGHTNESS **N** = NUMBNESS
W= WEAKNESS



Is your pain dull? Sharp? Does it radiate anywhere? If so, where?

_____

Since the problem started is it; About the same? ❑
Getting better? ❑ Getting worse? ❑

What have you done for this condition? Was it of benefit?

_____

_____

I do (do not) have a family history of this or similar symptoms

(Please explain): _____

_____

_____

What activities aggravate your condition?

_____

_____

_____

_____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following?
❑ Work ❑ Sleep ❑ Daily Routine ❑ Sports/exercise ❑ Other(Explain)_____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us to help you!

Has child had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Current Medicines and Supplements

Please list any medications/drugs child has taken in the past 6 months and why: (prescription and non-prescription) _____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies child presently takes and why:_____

_____

Are you interested in knowing more about how the food you eat affects your overall health and well-being? ❑ Yes ❑ No ❑ Maybe

If dietary changes are indicated would you be willing to make changes in your diet? ❑ Yes ❑ No ❑ Maybe

Would you take whole food supplements if indicated? ❑ Yes ❑ No ❑ Maybe

If specific exercises or stretching would help would you consider adding them to your program? ❑ Yes ❑ No ❑ Maybe

If reducing stress would help you would you like to know ways to reduce stress? ❑ Yes ❑ No ❑ Maybe

Diet; Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Eggs	Fasting	Artificial Sweetener
Fruit	Diet food	Weight Control Diet
Beef	Refined Sugar	Raw Vegetables
Poultry	Fish	Whole Grains
Organic foods	Seafood	Dairy
Fried Foods	Soda	Cooked or canned vegetables

Has child ever had any of the following diseases /health conditions (including just after birth and early infancy)?

❑HEART DISEASE/PROBLEMS ❑DISPLACED OR BROKEN JOINTS ❑JAUNDICE ❑HIGH/ LOW B.P.
❑SEVERE OR FREQUENT HEADACHES ❑POOR CIRCULATION ❑ARTHRITIS ❑KIDNEY PROBLEMS
❑FAINTING/ SEIZURES/ EPILEPSY ❑PSYCHIATRIC PROBLEMS ❑ANEMIA ❑BLADDER PROB/BEDWET.
❑RESPIRATORY PROBLEMS ❑FEEDING PROBLEMS ❑EMPHYSEMA ❑ALLERGIES/ SINUS PROB.
❑COLIC/DIGESTION PROB ❑ASTHMA/ BREATHING PROB. ❑TUBERCULOSIS ❑RHEUMATIC FEVER
❑CANCER/ CHEMOTHERAPY ❑FREQUENT NECK PAIN ❑DIABETES ❑OTHER _____

Please list anything that your child may be allergic to: _____

_____

Please list previous surgeries/ hospitalization with dates: _____

Please list any **past** serious accidents: _____

Has child had spinal X-Rays? ❑YES ❑NO When? _____

Is your child accident prone? ❑YES ❑NO

MOTHER'S PREGNANCY & LABOR; During pregnancy, did the mother do any of the following?
❑Take any medication ❑Smoke or consume alcohol ❑Experience any illness Explain _____
Approximately how long did labor last? _____hours Was labor chemically induced? ❑No ❑Yes
Was labor doctor assisted? ❑No ❑Yes Was a C-Section performed? ❑No ❑Yes
Were forceps or vacuum extraction used ❑No ❑Yes Is child 'accident prone'? ❑No ❑Yes
Was the delivery premature? ❑No ❑Yes If "Yes", at____ weeks and _____weight
Did the doctor pull or twist the baby during delivery? ❑No ❑Yes Is interacting with others difficult? ❑No ❑Yes
Does your child exhibit nervousness, twitching, shaking or rocking behavior? ❑No ❑Yes
What health goals would you like child to achieve?_____
Have you chosen to vaccinate your child? ❑No ❑Yes If "Yes", check vaccinations your child has received.
❑DPT ❑MMR ❑Polio❑Chicken Pox❑Hepatitis ❑Flu ❑HPV ❑Other _____

Describe any and all reactions to vaccine(s) _____

Stressors

Accumulation of stress affects our health and ability to heal. Please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade child's present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

_____ at Home _____ at Work _____ at Play

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe child's:

_____ Eating Habits _____ Exercise _____ Sleep _____ General Health _____ Mind Set

How do you grade child's physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade child's emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand your child which has not yet been discussed?

_____

_____

_____

_____

I consent to a professional, complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

I, _____ have read and fully understand the above.
PRINT NAME

_____ _____

PATIENT'S SIGNATURE DATE GUARDIAN'S SIGNATURE AUTHORIZING CARE DATE