



— GET WELL —
CHIROPRACTIC

Case Number _____

Today's Date _____

CA _____ DC _____

Tell Us About Your Child

First: _____ MI: _____ Last: _____ Nickname: _____

Current address: _____

City: _____ State: _____ Zip: _____ SS #: _____ - _____ - _____

Birth Date: ____/____/____ Male Female

Parent/Guardian: _____ Relationship: _____

Primary Phone: _____ - _____ - _____ H / W / C Email: _____

In which format do you prefer appointment reminders?

Email (above) Text message—provider: _____ Phone: _____ - _____ - _____

Whom may we thank for referring you? _____

Tell Us How We Can Help Your Child

What is the primary reason for your visit? Health Assessment (skip to page 2) -OR-

Health problem: _____

Is this due to a: Automobile accident Personal injury case None

When did your child's pain/symptoms begin (include date if possible)? _____

The overall severity of your child's complaints/concerns is:

Mild Mild to moderate Moderate Moderately severe Severe

The overall frequency is: Occasional Intermittent Frequent Constant

On a scale of 0 to 10, how would you rate your child's pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If the symptoms change, when are they worse: Morning Afternoon Evening Night NA

Are your child's symptoms/pain getting: Better Worse Staying the same

Has your child had recent treatment for this condition? No Yes—please list dates and doctors:

Has your child had the same or similar problems in the past? No Yes—When: _____

Since the symptoms began, have you noticed any function changes: Bowel Bladder No Changes

Tell Us About Your Child's Family Health History

Relative	Illnesses	Age	Cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Sister 1	_____	_____	_____
Sister 2	_____	_____	_____
Brother 1	_____	_____	_____
Brother 2	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Tell Us About Your Child's Health

Please mark any of the following conditions/illnesses for your child as NOW HAVE (○) or had IN THE PAST (□):

**NOW HAVE
IN THE PAST**

- Allergies
- Hay Fever
- Fatigue or Weakness
- Unexpected Weight Change
- Jaw Pain/TMJ
- Sleeping Problems
- Skin Problems/Rash/Eczema
- Loss of Balance
- Dizziness or Lightheadedness
- Vertigo
- Fainting
- Headaches
- Neck/Back/Growing Pains
- Seizures/Neurological Ticks
- Vision Trouble
- Hearing Trouble
- Ear Aches/Infections
- Ringing or Buzzing in Ears
- Loss of Smell
- Loss of Taste
- Difficulty Swallowing
- Difficulty Speaking
- Sinus Trouble
- Asthma

**NOW HAVE
IN THE PAST**

- Wheezing
- Chronic Cough
- Shortness of Breath
- Chest Pain or Pressure
- Heart Trouble
- High Blood Pressure
- Low Blood Pressure
- Cold Hands or Feet
- Abdominal Pain
- Indigestion / Upset Stomach
- Colic
- Excess Gas
- Heartburn
- Constipation
- Diarrhea
- Nausea or Vomiting
- Bedwetting
- Urinary Pain or Frequency
- Kidney or Bladder Trouble
- Blood in Urine or Stool
- Excessive Thirst
- Anxiety or Nervousness
- Mood Swings or Irritability
- Mental/Emotional Difficulty

**NOW HAVE
IN THE PAST**

- Depression
- Scoliosis
- Recurring Fevers
- Frequent Colds
- Bone Fracture
- Dislocated Joints
- Autoimmune Disease
- Cancer
- Diabetes
- Multiple Sclerosis
- Rheumatic Fever
- Tuberculosis
- Chicken Pox
- Whooping Cough
- Rubeola (Measles)
- Mumps
- Rubella (German Measles)
- Other: _____
- Other: _____
- Other: _____
- No Conditions/Illnesses**

Additional information and/or description: _____

Prenatal History

Complications during pregnancy? No Yes—(list)_____

Ultrasounds during pregnancy? No Yes—how many?_____

Medications during pregnancy/delivery? No Yes—(list)_____

Smoking/alcohol during pregnancy? No Yes—(describe)_____

Birth History

Location of birth: Hospital Birthing Center Home

Birth intervention: Forceps Vacuum Extraction Cæsarian Section— Emergency or Planned

Complications during delivery? No Yes—(list)_____

Genetic disorders or disabilities? No Yes—(list)_____

Birth weight: _____ lbs. _____ oz. Birth length: _____ in. APGAR scores: _____

Feeding History

Breast Fed: No Yes—How long?_____ Formula Fed: No Yes—How long?_____

Introduced to solids at: _____ months; cows milk at _____ months

Food allergies or intolerances: No Yes—(list)_____

Developmental History

At what age was your child able to:

Respond to sound: _____ Respond to visual stimuli: _____ Hold head up: _____

Sit up: _____ Cross crawl: _____ Stand alone: _____ Walk alone: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (e.g. bed, changing table, down stairs, etc.). Did your child fall? No Yes

Is/has your child been involved in any high impact or contact type activities (e.g. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? No Yes—_____

Has your child ever been involved in a car accident? No Yes—_____

Has your child been seen on an emergency basis? No Yes—_____

Has your child had surgery? No Yes—_____

Other traumas? No Yes—_____

Menarche? No Yes—Age:_____

Number of doses of antibiotics your child has taken during past six months: _____; during lifetime: _____

No. of doses of other medications s/he has taken during past six months: _____; during lifetime: _____

List other medications (prescription and over-the-counter):_____

Is your child currently taking any nutritional supplements: No Yes—please indicate which one/s:_____

Mandatory Electronic Health Records

In compliance with federal government requirements for the EHR program.

Preferred language: English Chinese French German Italian Japanese
 Korean Polish Portuguese Russian Spanish Tagalog Vietnamese

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined Unknown

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Declined Unknown

Other Health Care Providers

Has your child ever been to a doctor of chiropractic before? No Yes—How long ago? _____

Name of prior DC: _____ City/State: _____

Does your child see a pediatrician or osteopath? No Yes—Date of last visit: _____

Name of MD: _____ City/State: _____

Communication is Key to a Positive Relationship

Is there anything else you would like us to know? No Yes— _____

To help us ensure clarity of communication, please initial the following:

_____ I acknowledge that I was presented with a copy of the Notice of Privacy Practices on my initial visit which describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Get Well Chiropractic. Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices is on display in the reception room and on Get Well Chiropractic's website at www.getwellnorthville.com. We encourage you to read it in full. You may obtain additional copies of our most current notice by requesting it from our privacy official, Jenni Gowing. If you have any questions regarding this notice of our health information privacy policies, please contact Jenni Gowing, our privacy official.

_____ Get Well Chiropractic may send me birthday cards and holiday greetings.

_____ Get Well Chiropractic may send me personal correspondence (notification of special events, closures, special offers, referral gifts, etc.)

_____ To the best of my knowledge the questions on this form have been accurately answered.

I understand that providing incorrect or incomplete information can be detrimental to my health.

It is my responsibility to inform Get Well Chiropractic of any changes in my health status.

Name of Patient: _____ Date: _____

Personal Representative: _____ Relationship: _____

Signature: _____ Witness: _____