GET WELL
CHIROPRACTIC

Case Number

Today's Date

CA DC

Tell Us About Your Child

Title:_____ First:_____ MI:___ Last:_____

Nickname:_____ Birth date:_____ Age:_____ Sex: ❒ Male ❒ Female

Current address:_____

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

Primary Tel:_____-_____-_____ H / W / C Alt. Tel:_____-_____-_____ H / W / C

Email:_____

Parent/Guardian: _____ Relationship: _____

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		NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST	
❍	❒	Allergies	❍	❒	Wheezing	❍	❒	Depression
❍	❒	Hay Fever	❍	❒	Chronic Cough	❍	❒	Scoliosis
❍	❒	Fatigue or Weakness	❍	❒	Shortness of Breath	❍	❒	Recurring Fevers
❍	❒	Unexpected Weight Change	❍	❒	Chest Pain or Pressure	❍	❒	Frequent Colds
❍	❒	Jaw Pain/TMJ	❍	❒	Heart Trouble	❍	❒	Bone Fracture
❍	❒	Sleeping Problems	❍	❒	High Blood Pressure	❍	❒	Dislocated Joints
❍	❒	Skin Problems/Rash/Eczema	❍	❒	Low Blood Pressure	❍	❒	Autoimmune Disease
❍	❒	Loss of Balance	❍	❒	Cold Hands or Feet	❍	❒	Cancer
❍	❒	Dizziness or Lightheadedness	❍	❒	Abdominal Pain	❍	❒	Diabetes
❍	❒	Vertigo	❍	❒	Indigestion / Upset Stomach	❍	❒	Multiple Sclerosis
❍	❒	Fainting	❍	❒	Colic	❍	❒	Rheumatic Fever
❍	❒	Headaches	❍	❒	Excess Gas	❍	❒	Tuberculosis
❍	❒	Neck/Back/Growing Pains	❍	❒	Heartburn	❍	❒	Chicken Pox
❍	❒	Seizures/Neurological Ticks	❍	❒	Constipation	❍	❒	Whooping Cough
❍	❒	Vision Trouble	❍	❒	Diarrhea	❍	❒	Rubeola (Measles)
❍	❒	Hearing Trouble	❍	❒	Nausea or Vomiting	❍	❒	Mumps
❍	❒	Ear Aches/Infections	❍	❒	Bedwetting	❍	❒	Rubella (German Measles)
❍	❒	Ringing or Buzzing in Ears	❍	❒	Urinary Pain or Frequency	❍	❒	Other:_____
❍	❒	Loss of Smell	❍	❒	Kidney or Bladder Trouble	❍	❒	Other:_____
❍	❒	Loss of Taste	❍	❒	Blood in Urine or Stool	❍	❒	Other:_____
❍	❒	Difficulty Swallowing	❍	❒	Excessive Thirst	❍	❒	**No Conditions/Illnesses**
❍	❒	Difficulty Speaking	❍	❒	Anxiety or Nervousness			
❍	❒	Sinus Trouble	❍	❒	Mood Swings or Irritability			
❍	❒	Asthma	❍	❒	Mental/Emotional Difficulty			

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 ❒ Ceasarian 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:_____