Gabbert Chiropractic

Dr. Tracy L. Gabbert
Chiropractor
www.glendivechiropractor.com

CHILD'S HEALTH RECORD

ABOUT THE CHILD

CHILD'S NAME:

ADDRESS:

CITY:	STATE/ZIP CODE:
DATE OF BIRTH:	AGE:

GENDER:	HEIGHT:	WEIGHT:

ABOUT THE PARENT'S

PARENT'S NAMES:

ADDRESS:

❑ SAME AS ABOVE

CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:

EMAIL ADDRESS:

EMPLOYER:

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now has or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ ALLERGIES	❑ CONSTIPATION	❑ IRRITABILITY
❑ ASTHMA	❑ DIGESTIVE PROBLEMS	❑ SKIN PROBLEMS
❑ ATTENTION PROBLEMS	❑ EAR INFECTIONS	❑ SLEEPING DISORDERS
❑ BED WETTING	❑ FREQUENT COLDS	❑ TUBES IN THE EARS
❑ BREATHING PROBLEMS	❑ HEADACHES	❑ VISION PROBLEMS
❑ COLIC	❑ HYPERACTIVITY	❑ GROWING PAINS
❑ OTHER:__________	❑ OTHER:__________	❑ OTHER:__________

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO

HOW MANY VACCINATIONS HAS YOUR CHILD HAD?
❑ ALL ❑ MOST ❑ SOME EXPLAIN:

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
❑ FEVER ❑ LETHARGY ❑ FUSSINESS ❑ SEIZURES

CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR WELLNESS CENTER BECAUSE OF (CHECK ALL THAT APPLY):
❑ FRIENDS & FAMILY ❑ CO-WORKERS ❑ INTERNET ❑ MAILING
❑ SIGN ❑ COMMUNITY EVENT ❑ NEWSPAPER

HAS YOUR CHILD BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ WELL CHECK ❑ FALL ❑ HOME INJURY ❑ SPORTS ❑ AUTO
PLEASE EXPLAIN:

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
❑ SCHOOL ❑ PLAY ❑ BEHAVIOR
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

BOSS Printing, Glendive, MT/GabbertChiropractic-ChildHealth (9-13)

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:
❑ DRUGS/MEDICATIONS ❑ TOBACCO/ALCOHOL

IF YES, PLEASE EXPLAIN:

WAS THE BABY EVER IN THE BREECH POSITION? ❑ YES ❑ NO

DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? ❑ YES ❑ NO
HOW MANY?__________

DESCRIBE YOUR DELIVERY:

❑ LABOR WAS CHEMICALLY INDUCED ❑ EPIDURAL
❑ C-SECTION DELIVERY ❑ FORCEPTS/VACUUM EXTRACTION
❑ DOCTOR PULLED OR TWISTED BABY ❑ PREMATURE DELIVERY
❑ HOME BIRTH ❑ WATER BIRTH ❑ DULA/MIDWIFE ASSISTED

PLEASE EXPLAIN:

HOW LONG WAS THE LABOR?____________________

HOW LONG WAS THE DELIVERY?____________________

DID YOU EXPERIENCE ANY ILLNESS(S)/COMPLICATIONS WHILE PREGNANT? ❑ YES ❑ NO
PLEASE EXPLAIN:

DID YOU BREASTFEED? ❑ YES HOW LONG?__________ ❑ NO

DID YOU EXPERIENCE FEEDING PROBLEMS? ❑ YES ❑ NO

DID YOUR BABY HAVE COLIC? ❑ YES ❑ NO

VACCINATIONS DURING PREGNANCY? (EX. FLU SHOT) ❑ YES ❑ NO

ARE YOU AWARE THAT

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVES SYSTEM?
❑ YES ❑ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

THE NERVES SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
❑ YES ❑ NO

IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE?
❑ YES ❑ NO

CHILD'S CURRENT HEALTH

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ❑ YES ❑ NO
NUMBER OF DOSES____________________
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER FALLEN FROM A HEIGHT OVER 3 FEET?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO
PLEASE EXPLAIN:

IS YOUR CHILD ACCIDENT PRONE? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ❑ YES ❑ NO
PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
❑ YES ❑ NO PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES, OR EXHIBITS ROCKING BEHAVIOR?
❑ YES ❑ NO PLEASE EXPLAIN:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

Consent to evaluate and adjust a minor child

I,________________________________ being the parent or legal guardian of____________________________ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care. In addition, the statements made on this form are accurate to the best of my recollection.

____ ________________
Signature Date

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