



ROGERS CHIROPRACTIC CENTER

CHILD HEALTH HISTORY

We are pleased to welcome you to our practice. To save time and allow us to better serve you, please complete all the information required. If you have any questions, we will be happy to help.

| | | | | | |
|--|---|--|---|---|-------------------------|
| TODAYS DATE: | | | | | |
| 1. Name (Last, First, Middle Initial) | | 2. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 3. Social Security # - - | | 4. Age |
| | | | | | 5. Date of Birth / / |
| 6. Address City State Zip | | | 7. Home Telephone # | | |
| 8. Name of School | | 9. Grade | 10. Sports & Activities Performed by Patient | | |
| 11. Name, Telephone, and Address of Person Responsible for this Account | | | | 12. Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Company's Name: Subscriber Name: Subscriber Birthday: / / Relationship to Subscriber: | |
| 13. Name of Father | 14. Does the Father have any Health Problems? | | | | |
| 15. Name of Mother | 16. Does the Mother have any Health Problems? | | | | |
| 17. # of Siblings | 18. Name(s) & Age(s) of Siblings | | 19. Do your Siblings have any Health Problems? | | |
| 20. Referred By: | 21. Hours of Sleep per Night | | 22. Quality of Sleep: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | | |
| 23. Any Difficulties with Birth? | | 24. Any Difficulties after Birth? | | | |
| 25. Have you had Chiropractic Care Before? <input type="checkbox"/> Yes Where? When? <input type="checkbox"/> No | | 26. Name, Address, & Telephone # of Pediatrician/Family Doctor | | | |
| 27. Have you ever had any accidents, injuries, or major falls? | Month, Year | Type | Describe Injury | | |
| 28. Have you ever had any Surgery? | Month, Year | Type | Describe Injury | | |
| 29. Are you currently taking any Medication? | Month, Year | Type | Reason for Taking it | | |
| 30. Are you currently taking any Nutritional Supplements? | Month, Year | Type | Reason for Taking it | | |

Health History

Check any of the following conditions that you have had within the last year.

MUSCULO-SKELETAL

- Arthritis
- Arms/Hands Pain
- Hip Pain
- Jaw Problems
- Joints Pain
- Legs/Feet Pain
- Low Back Pain
- Mid Back Pain
- Neck Pain
- Osteoporosis
- Shoulder Pain/Tightness
- Stiffness

NERVOUS

- Face Twitching
- Fainting
- Nervousness
- Numbness/Tingling
- Pinched Nerve
- Seizures/Convulsions
- Tremors

FEMALE (ONLY)

- Breast Pain/Lumps
- Menstrual Cramps
- Menstrual Irregularity
- Vaginal Pain/Infections

C-V-R

- Ankle Swelling
- Asthma
- Blood Pressure Problems
- Chest Pain
- Chronic Cough
- High Cholesterol
- Shortness of Breath

GASTRO-INTESTINAL

- Abdominal Pain/Cramps
- Black/Bloody Stool
- Constipation
- Diarrhea
- Excessive Thirst
- Frequent Nausea/Vomiting
- Heartburns
- Hemorrhoids
- Hernia
- Poor Appetite
- Ulcers

GENITO-URINARY

- Bed Wetting
- Bladder Problems
- Discolored Urine
- Excessive Urination
- Painful/Burning Urination

EENT

- Ear/Hearing Problems
- Ear Infections
- Eye/Vision Problems
- Nose/Smelling Problems
- Sinus Problems
- Throat Problems

SKIN

- Itching/Rash
- Skin Problems
- Tumors/Cysts/Lumps

GENERAL

- Allergies
- Cold Sweats
- Depression
- Dizziness
- Difficulty Sleeping
- Fatigue
- Headaches
- Memory Problems
- Sudden Loss of Weight
- Swelling

MALE (ONLY)

- Genital Problems
- Prostate Problems

Check any of the following diseases that you have had in your life.

- AIDS/HIV
- Alcoholism
- Anemia
- Anorexia
- Bulimia
- Cancer
- Chemical Dependency
- Diabetes
- Disc Herniation
- Gout

- Hayfever
- Heart Problems
- Kidney Problems
- Liver Problems
- Lung Problems
- Measles
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps

- Paralysis
- Pneumonia
- Polio
- Shingles
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Venereal Disease
- Whooping Cough

Family History

Check any of the following family members that had any of the diseases mentioned above.

- Father: _____
- Mother: _____
- Brother: _____
- Sister: _____
- Spouse: _____
- Child: _____
- Uncles/Aunts: _____
- Grandparents: _____

Patient Name: _____ Date: _____

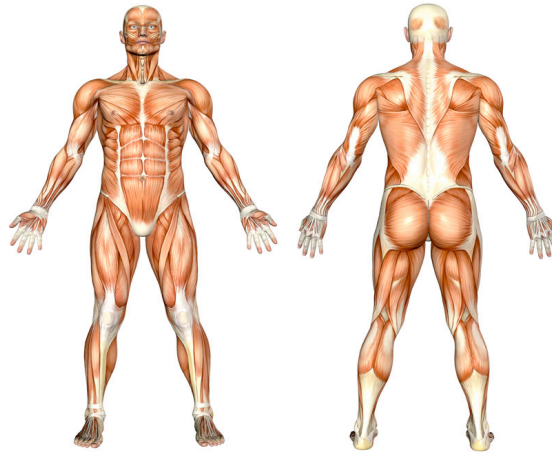
Your Current Condition

Patient Name: _____ Date: _____

1. Chief Complaint: _____

2. Is today's problem caused by: Auto Accident Workman's Compensation Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

5. How would you describe the type of pain?

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting | <input type="checkbox"/> Shooting with Motion |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Stiff | <input type="checkbox"/> Stabbing with Motion |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Numb | <input type="checkbox"/> Electric like with Motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Tingly | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp with Motion | |

6. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem? (Please Circle)

0 1 2 3 4 5 6 7 8 9 10

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

10. Who else have you seen for your problem?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER Physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one |

11. How long have you had this problem? _____

12. How do you think your problem began? _____

13. Do you consider this problem to be severe? Yes Yes, at times No

14. What aggravates your problem? _____

15. What concerns you the most about your problem; what does it prevent you from doing? _____

16. What is your: Height _____ Weight _____ Occupation _____

17. How would you rate your overall health? Excellent Very Good Fair Poor

18. What type of exercise do you do? Strenuous Moderate Light None

19. What activities do you do at work?

| | | | |
|----------------|--|---------------------------------------|--|
| Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| Computer Work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

20. What activities do you do outside of work? _____

21. Have you ever been hospitalized? Yes No

If yes, why? _____

22. Anything else pertinent to your visit today? _____

I certify that I have read, understood, and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient (or parent if minor)

Date

Authorization

I authorize Rogers Chiropractic Center to release any information concerning my condition to any insurance company, attorney, or health practitioner. I authorize direct payment to Rogers Chiropractic Center for any sum that I owe now or in the future; from any insurance company that is obligated to reimburse me for changes incurred in your office, or my attorney out of the proceeds of my settlement. A photocopy of this form is acceptable for payment. I hereby assign and give to Rogers Chiropractic Center the right to take action against any insurance company that is obligated by contract to make payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf, or my dependants, and pay it within a 90 day period. I understand that in the event that my account is past due, I will be charged and I will be responsible for an additional \$20.00 fee.

Signature of Patient (or parent if minor)

Date

Signature of Witness

Date

Consent For Treatment & X-ray Policy

It is understood and agreed upon that the amount paid at Rogers Chiropractic Center for x-rays is for examination only. X-ray negatives will remain the property of this office, and could be seen at any time while the person is still a patient at this office. A copy of the x-rays may be provided for a fee. I hereby authorize Dr. Dayne Rogers, and whomever he may designate as his assistant, to administer treatment to me and my dependants as he so deems necessary.

Is it possible that you are pregnant? Yes No

Signature of Patient (or parent if minor)

Date

Signature of Witness

Date