Healthful Chiropractic
Jason Alder DC, UCA
2150 S. Central Expy, Suite 200
McKinney, Texas 75070
469.215.1385
www.HealthfulChiropractic.com

CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Patient Information

Name: _____

Address: _____

Birthdate: _____

Parent Name: _____

Parent Name: _____

Primary Care Provider: _____

Referred By: _____

Contact Information

Home Phone _____

Cell Phone _____

Work Phone _____

eMail _____

Best way to reach you: ☐ Home phone ☐ Cell Phone ☐ eMail

Emergency Contact: _____

Phone _____

Patient History and Condition

Major symptom/problem _____

When did symptom begin? _____

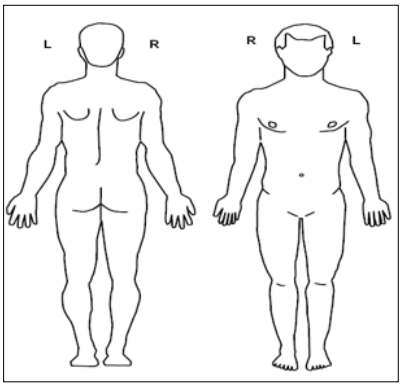
Have they had this problem before? _____

Is the problem getting progressively worst? _____

Is the problem: ☐ Constant ☐ Comes and goes

Does it cause problems elsewhere? _____

Please mark the areas affected on the diagram →



Circle the severity of discomfort on a scale of 0 - 10 (if able).

(no discomfort) 0 1 2 3 4 5 6 7 8 9 10 (severe discomfort)

What makes the condition better? _____ What makes the it worst? _____

How does the problem affect your child's body function and activities? _____

History of Birth

Hospital/Birthing Center: ☐ Home ☐ Medical ☐ Midwife Duration of Gestation: wks

Was the birth assisted? ☐ Yes ☐ No If yes, how? ☐ Forceps ☐ Vacuum ☐ C-Section ☐ Induced

Were medications given to the mother at birth? ☐ Yes ☐ No Duration of Birth:

Was the delivery normal? ☐ Yes ☐ No If no, what complications? _____

The following information is important because many problems are caused by stressors

Chemical Stressors

During pregnancy, did the mother: ☐ Smoke ☐ Drink Alcohol ☐ Take vitamins/supplements ☐ Become ill

Was your child breast fed? ☐ Yes ☐ No If yes, how long: _____

Was the child vaccinated? ☐ Yes ☐ No If yes, which ones: _____

Antibiotic use or other meds? ☐ Yes ☐ No If yes, how long: _____

Consultation Notes

CONFIDENTIAL HEALTH INFORMATION

Doctor's Initial _____

Psychological Stressors

Any difficulties with lactation? ☐ Yes ☐ No Any problem bonding? ☐ Yes ☐ No

Behavior issues? ☐ Yes ☐ No If yes, specify: _____

Does you child have difficulties sleeping? ☐ Yes ☐ No If yes, specify: _____

Did/does your child go to daycare? ☐ Yes ☐ No From what age? _____

Traumatic Stressors

Any evidence of trauma during birth? ☐ Bruises ☐ Odd shaped head ☐ Stuck in birth canal ☐ Breech birth

☐ fast or excessively long birth ☐ Respiratory difficulties ☐ Cord around neck ☐ Other

Any falls/accidents during pregnancy? ☐ Yes ☐ No Has your child had any major falls since birth? ☐ Yes ☐ No

Any hospitalizations or surgeries? ☐ Yes ☐ No If yes, Please explain: _____

Does your child play sports? ☐ Yes ☐ No Weight of child's backpack?

Check any of the following conditions or recent experiences:

☐ Colic	☐ Loss of Weight	☐ Sleeping Problems	☐ Feeding Problems
☐ Excessive spitting up	☐ Frequent Choking	☐ Jaundice	☐ Night Sweats
☐ Constipation/Diarrhea	☐ Congenital Abnormalities	☐ Fever	☐ Infections
☐ Allergies	☐ Asthma/Breathing Problem	☐ Pneumonia/Bronchitis	☐ Tonsillitis
☐ Headaches	☐ Eye Problems	☐ Loss of smell/taste	☐ Sinus Problems
☐ Recurrent ear infection	☐ Hearing Problems	☐ Bladder Problems	☐ Bedwetting
☐ Indigestion/Heartburn	☐ Ulcers	☐ Heart Problems	☐ Nausea/Vomiting
☐ Fatigue/Weakness	☐ Scoliosis	☐ Frequent Colds/Illness	☐ Loss of Balance
☐ Clumsiness	☐ Dizziness/Fainting	☐ Loss of Consciousness	☐ Learning Problems
☐ Anxiety/Depression	☐ Physical/Mental Abuse	☐ Attention Problems	☐ Diabetes

Has your child ever had any x-rays, CT scans, MRI's? ☐ Yes ☐ No Which part & year _____

Initials _____ I instruct the chiropractor to deliver the care that, in his professional judgement, can best help my child in the restoration of health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of health concern.

Print the child's name: _____

Parent Signature: _____ Date: _____

Consultation Notes

Patient Name _____

Patient Number _____

Doctor's Initial _____

Date _____