

# Child's Health History

## CARUSO CHIROPRACTIC CLINIC

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'll 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. What 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:		
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. # of hours sleep a 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. Any Previous Chiropractic Care? <input type="checkbox"/> YES <input type="checkbox"/> NO Where?		26. Name, address, & telephone # of Pediatrician/Family Doctor			
26. Have you ever had any accidents, injuries, or major falls? <input type="checkbox"/> YES <input type="checkbox"/> NO	Month, Year	Type	Describe Injury		
27. Have you ever had any surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO	Month, Year	Type	Describe Injury		
28. Are you currently taking any medication? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name	Dosage	Reason for taking it		
29. Are you currently taking any Nutritional Supplements? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name	Dosage	Reason for taking it		

## Health History

Check any of the following conditions that the child has had within the last year.

### MUSCULO-SKELETAL

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

### NERVOUS

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

### SKIN

- Skin Problems
- Tumors/Cysts/Lumps

### C-V-R

- Asthma
- Chest Pain
- Chronic Cough
- Shortness of Breath

### GASTRO-INTESTINAL

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

### GENITO-URINARY

- Bed Wetting
- Bladder Problems
- Discolored Urine
- Genital Problems
- Painful/Burning urination

### EENT

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

### GENERAL

- Allergies
- Behavioral Problems
- Cold Sweats
- Depression
- Dizziness
- Fatigue
- Headaches
- Memory Problems
- Sudden Loss of Weight
- Swelling
- Others: \_\_\_\_\_

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

AIDS/HIV

Anemia

Anorexia

Bulimia

Cancer

Chickenpox

Colic

Congenital Anomalies

Diabetes

Disc Herniation

Hayfever

Heart Problems

Juvenile Arthritis

Kidney Problems

Liver Problems

Lung Problems

Measles

Mononucleosis

Multiple Sclerosis

Mumps

Paralysis

Pneumonia

Polio

Rheumatic Fever

Rubella

Rubeola

Suicide Attempt

Thyroid Problems

Tuberculosis

Whooping Cough

Others: \_\_\_\_\_

## Family History

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

Father: \_\_\_\_\_

Sister: \_\_\_\_\_

Uncles/Aunts: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

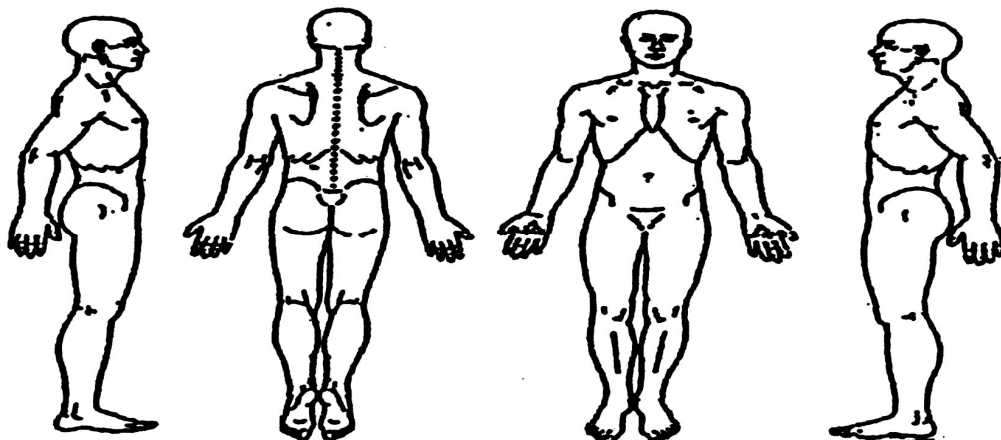
# Your Current Condition

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?

- Sharp  Numb  
 Dull  Tingly  
 Diffuse  Sharp with motion  
 Achy  Shooting with motion  
 Burning  Stabbing with motion  
 Shooting  Electric like with motion  
 Stiff  Other: \_\_\_\_\_

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?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

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

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

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

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

10. Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician  
 ER physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  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  Good  Fair  Poor

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

**19. What activities do you do at work?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of 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?  No  Yes

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 Caruso Chiropractic Clinic to release any information concerning my condition to any insurance company, attorney, or health practitioners. I authorize direct payment to Caruso Chiropractic Clinic for any sum that I owe now or in the future, from any insurance company that is obligated to reimburse me for charges 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 Caruso Chiropractic Clinic 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 dependents, and pay it within a 90 day period. I understand that in the event 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 Caruso Chiropractic or 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. Sam Caruso, and whomever he may designate as his assistant, to administer treatment to me or my dependents as he so deems necessary.

Could you it be possible that you are pregnant?  YES  NO

\_\_\_\_\_  
Signature of Patient (or parent of minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date