Katz Wellness Center

CHILD MEMBER HEALTH FORM

About the child

Patient Name:			
Address:			
City:		State/Zip:	
Home Phone:		Family Physician:	
Date of Birth:	Current Age:	Weight:	Sex: □ Male □ Female

Medications / Vaccinations

Number of doses of prescription medication child has taken during his/her lifetime:	
Please list all medications:	
Have you chosen to vaccinate your child? □ Yes □ No	If yes, please check all that apply: □ DPT □ MMR □ Chicken Pox □ Hepatitis □ Other
Describe any and all reactions to vaccines:	

About the Parent

Please list your name and the name of your spouse (if applicable): Are you the □ Parent □ Legal Guardian		
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed		Address: □ Same as above
City:	State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Employer Name:	Employer Address:	
Email Address:		

Reason for this visit

Describe the reason for this visit: □ Wellness □ Health Condition (please explain)	
Is the purpose of this appointment related to: □ Sports □ Auto □ Fall □ Home Injury □ Other (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 (please explain)	
Has this condition occurred before? □ Yes □ No (please explain	
Have you seen other chiropractors or doctors for this condition? □ Yes □ No	That Doctor's name:
Type of treatment:	Results:

Prenatal HISTORY (Complete This Page ONLY for Children Ages Infant to 5 years)

During pregnancy did you use: □ Tobacco/Alcohol □ Drugs/Medication (please describe below)

Location of birth: □ Home □ Birthing Center □ Hospital

Describe your delivery:

□ Labor was chemically induced □ C-Section Delivery □ Premature delivery
□ Labor was doctor assisted □ Forceps/Vacuum extraction

Describe any complications experienced during delivery:

Did you experience any illness(s) while pregnant? □ Yes □ No (if yes, please explain)

Please describe any genetic disabilities:	Ultrasound during pregnancy? □ Yes □ No Number of ____
Birth Weight: Birth Length: Apgar Scores:	Did you breastfeed the baby? □ Yes □ No how long ____ Did you formula feed the baby? □ Yes □ No how long ____
At what age did you introduce: Solids: Cow's Milk:	Are you aware of any food/drink allergies or intolerance? □Yes □No

Lifestyle Habits

Does your child exercise daily? □ Yes □ No how much? _____

Does your child drink soda? □ Yes □ No how much? _____

Does your child take vitamins? □ Yes □ No list them _____

Does your child play video or computer games? □ Yes □ No how much? _____

Does your child watch more than an hour of TV per day? □ Yes □ No how much? _____

Does your child eat balanced meals? □ Yes □ No

Does your child experience prolonged sadness? □ Yes (explain) □ No

Current Health Status

The National Safety Council Reports Approximately 50% of children fall head first from a high place during their first year of life (I.E.: bed, changing table, stairs, etc.).

Was this the case for your child? □ Yes □ No (if yes, please explain)

Has your child ever been hospitalized or had surgery? □ Yes □ No (if yes, please explain)

Has your child ever been in a car accident? □ Yes □ No (if yes, please explain)

Does your child have difficulty interacting with others? □ Yes □ No

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?
□ Yes □ No (if yes, please explain)

lifestyle behaviors (Complete This Page ONLY for Children Ages 6-10 Years of Age)

Lifestyle Habits

Does your child exercise daily? □ Yes □ No how much? _____

Does your child take vitamins? □ Yes □ No (if yes, please list)

Does your child drink soda? □ Yes □ No how much? _____

Does your child have difficulty sleeping? □ Yes □ No

Does your child play video games? □ Yes □ No how much? _____

Does your child watch more than an hour of TV per day? □ Yes □ No how much? _____

Does your child eat balanced meals? □ Yes □ No

Does your child experience prolonged sadness? □ Yes (explain) □ No

Child's Health History

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now 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.*

□ Asthma	□ Diarrhea	□ Learning Disorders	□ Urinary Infections
□ Bed Wetting	□ Ear infections	□ Nervousness	
□ Bronchitis	□ Headaches	□ Sore throat	
□ Constipation	□ Hyperactivity	□ Upset stomach	

Current Health Status

Has your child been involved in any high impact/contact type sports (i.e.: soccer, football, martial arts, cheerleading, etc.)? □ Yes □ No (if yes, please explain)

Has your child ever been hospitalized or had surgery? □ Yes □ No (if yes, please explain)

Has your child ever been in a car accident? □ Yes □ No (if yes, please explain)

Does your child have difficulty interacting with others? □ Yes □ No (if yes, please explain)

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? □ Yes □ No (if yes, please explain)

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10
Personal: 1 2 3 4 5 6 7 8 9 10

lifestyle behaviors (Complete This Page ONLY for Children 11-18 Years of Age)

Lifestyle Habits

Does your child exercise daily? □ Yes □ No how much? _____

Does your child take vitamins? □ Yes □ No (if yes, please list) _____

Does your child drink soda? □ Yes □ No how much? _____

Does your child have difficulty sleeping? □ Yes □ No

Does your child play video games? □ Yes □ No how much? _____

Does your child watch more than an hour of TV per day? □ Yes □ No how much? _____

Does your child eat balanced meals? □ Yes □ No

Does your child experience prolonged sadness? □ Yes (explain) □ No

Child's Health History

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now 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.*

□ Anxiety	□ Diarrhea	□ Hips, knees, ankles	□ Shoulders elbow, wrist
□ Asthma	□ Depression	□ Hyperactivity	□ Stress
□ Back pain stiffness	□ Difficult or irregular periods	□ Learning disorders	□ Urinary infections
□ Constipation	□ Headaches	□ Neck stiffness/pain	

Current Health Status

Has your child been involved in any high impact/contact type sports (i.e.: soccer, football, martial arts, cheerleading, etc.)? □ Yes □ No Please list:

Has your child ever been hospitalized or had surgery? □ Yes □ No (if yes, please explain)

Has your child ever been in a car accident? □ Yes □ No (if yes, please explain)

Does your child have difficulty interacting with others? □ Yes □ No (if yes, please explain)

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10
Personal: 1 2 3 4 5 6 7 8 9 10

ALMOST DONE!

Now we just need your consent to continue through our process.

I hereby request and consent to the performance of chiropractic examination, adjustments, x-rays (if necessary), and other procedures including various modes of physical therapy on me by Drs. Joshua & Jessica Katz and/or anyone working in this office authorized by Drs. Katz. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risk to treatment; including, but not limited to fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based on the facts known then.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment and for the conditions for which I seek treatment at this facility.

Parent or Guardian Authorizing Care Signature_____ Date: _____