Child Health Record

Date _____

Child's Name _____

Birth Date _____Age _____

Gender _____

Address _____Apt# _____

City _____ State _____ Zip _____

Phone _____

Email _____

Insurance _____

Weight at birth _____ Handedness if known ☐ R ☐ L

_____

Current Height _____ Current Weight _____

Parent Name _____

Who referred you this office?

_____

Have you or your child been to a chiropractor before?

☐ Yes ☐ No _____

Any illness or surgeries during the pregnancy? _____

_____

Describe the birth:

☐Vaginal ☐C-section ☐Forceps/Vacuum used

☐Premature Please explain _____

Feeding:

☐Breast ☐Bottle _____

☐Trouble Sucking _____

☐Child prefers one side _____

Describe the reason for this visit _____

_____

_____

_____

_____

Is this visit related to:

☐Exercise/Sports ☐Home Injury ☐Wellness ☐Job ☐Auto

☐Other _____

If there is pain, please rate your pain from 1-10 (10 = worst)

_____

Does the pain travel? ☐Y ☐N

Please explain _____

When did this condition begin? _____

Has this condition:

☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with:

☐Work ☐ Sleep ☐Daily Routine ☐Other Activities

_____

Has this condition occurred before? ☐Yes ☐No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name (s) _____

Type of treatment _____

Results _____

Describe previous MRI/X-ray results _____

_____

_____

Perline Chiropractic PC
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135 East 50th St., Ste 102, NYC 10022
100 North Centre Ave., Ste 202, RVC NY

Please check all that apply:

☐Sinus problems	☐Dizziness	☐Vision problems	☐Frequent colds
☐Weight gain/loss	☐Asthma	☐Colic	☐Scoliosis
☐Difficulty breathing	☐Bed wetting	☐Rheumatic fever	☐Hearing problems
☐Allergies	☐Loss of sleep	☐Kidney problems	☐Had a severe fall
☐Attention problems	☐Digestive problems _____		☐COVID - 19 date(s)_____
☐Hyperactivity	☐Not meeting mile stones _____		☐Irritability
☐Skin problems	☐Sleeping issues _____		☐Takes medications
☐Depression/Anxiety	☐Special Needs _____		

☐Prior illness, surgeries, injuries _____

☐Heart Condition - please explain _____

☐Severe or frequent headaches – please explain _____

☐Cancer – please explain _____

☐Arthritis +/or herniated discs – please explain _____

☐Autoimmune – please explain

_____☐Other – please explain

_____ General stress level ☐ low ☐Moderate ☐Severe Please explain _____ Family health history (diabetes, cancer, heart disease) _____

Authorizations

We do not offer to diagnose or treat conditions other than vertebral subluxation (spinal misalignments). A vertebral subluxation can cause pain or alteration of nerve function and interference of the transmission of nerve impulses. If during the course of your chiropractic care, we encounter non-chiropractic findings, we will refer you to the appropriate provider.

I understand the doctor's objectives pertaining to my care in this office and accept chiropractic care on this basis.

Protecting the privacy of your personal health information is important. Disclosure of your health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosure for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. A complete description can be made available to me upon request.

I authorize the release of any medical information necessary to process my insurance claims.

I understand that my insurance is an agreement between my insurance company and myself and all services rendered to me in this office are my responsibility. I understand that if I suspend or terminate my care, any fees for services rendered me will become immediately due and payable. I authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I authorize this office to communicate with me and/or send reminders through text, email and phone.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Name (Printed) _____

Parent/Guardian Signature _____ Relationship to patient _____