858 Hansen Road, Green Bay, WI 54304
(920) 499-1333 / Fax: (920) 499-2444

Children's Confidential Patient Health Record

Today's Date:____/_____/________

(*For patients under the age of 12*)

How did you hear about us? ☐ **Family** ________________ ☐ **Friend** ___________________ ☐ **Co-Worker** _________________
☐ **Close to home/work** ☐ **Dr.** ______________ ☐ **Yellow pages** ☐ **Drove by** ☐ **Insurance Plan** ☐ **Other:** _______________

Child's Personal Information

Last:____________________________ **First:**_____________________________ **Middle:** ______________________________

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III** ☐ **other:** _______________________

Birth Date: ____ /____/_______ **Age:**______ **Sex: Male / Female** **Social Security #:** _______-_______-________

Address: ____**Apt #** ______

City: ___________________ **State:** ______ **Zip:** _________

Home Phone: (_______) _______-_________ **Cell Phone:** (_______) _______-_________

Parent's/Legal Guardian's Contact Information

Last:____________________________ **First:**_____________________________

Address: ____**Apt #** ______

City: ___________________ **State:** ______ **Zip:** _________ **Country:** ___________________ **County:** ______________

Relationship: ☐ **Parent** ☐ **Legal Guardian** ☐ **Other** _______________________

Email Address: _________________________

Home Phone: (_______) _______-_________ **Cell Phone:** (_______) _______-_________

Work Phone: (_______) _______-_________ **ext** ______ **Fax #:** (_______) _______-_________

School Information

School: ____**Grade:** ____________________________________

What sports or other activities are you involved in?

☐ **band**	☐ **choir**	☐ **gymnastics**	☐ **volleyball**
☐ **baseball**	☐ **dance**	☐ **hockey**	☐ **wrestling**
☐ **basketball**	☐ **football**	☐ **soccer**	☐ **other:** _______________
☐ **cheerleading**	☐ **golf**	☐ **tennis**	_______________________

Reason for Visit

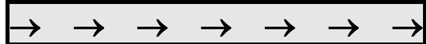
□ **Spinal Health Check-up**

Date of your child's last spinal health check-up? ___________________________ □ Never

□ **My child has a specific health condition that I heard chiropractic care may help with (please check):**

□ ADD/ADHD	□ clumsiness	□ headaches	□ temper tantrums
□ atopic dermatitis (eczema)	□ colic	□ HIV	□ other:___________
□ allergies/hayfever	□ constipation	□ Learning Disorders	__________________
□ anemia	□ crohn's/colitis	□ neck aches	
□ auto accident	□ depression	□ poor posture	
□ asthma	□ diabetes	□ psoriasis	
□ back aches	□ digestive problems	□ rash	
□ bedwetting	□ ear infections	□ recurring fever	
□ cerebral palsy	□ eye problems	□ scoliosis	
□ chicken pox	□ fetal drug exposure	□ seizure disorder	
□ chronic colds	□ growing pains		

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? _____/_______/_________

Has it ever occurred before? □ Yes □ No. When? ____________

Is the Condition: □ Auto Related □ Home Injury □ Slip or Fall

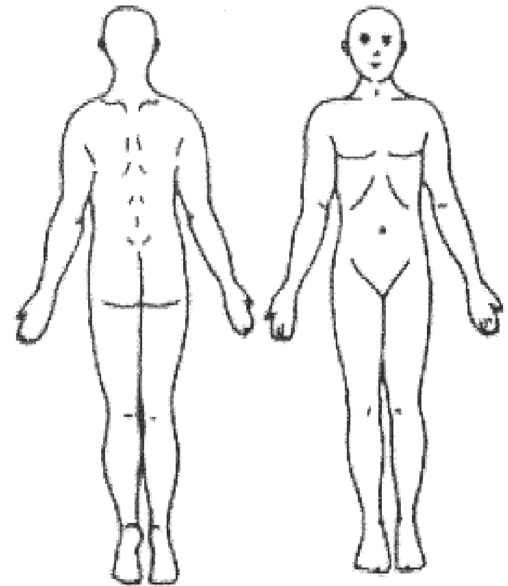
□ Lifting □ Slept Wrong □ Unknown Cause □ Other

Explain: ____

____

Date of Injury: _________ Time of Injury: ________ am /pm

Condition/Pain STARTED on what Date: ____________________



PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
□ My child has not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) ________________________

Type of Treatment: ____________________ Were you satisfied with the results of your treatment? □ Yes □ No

Explain: ____

Medication (s):

Number of doses of antibiotics your child has taken:
During the past six months: __________ , Total during his/her lifetime: __________

Number of doses of other prescription mediations your child has taken:
During the past six months: __________, Total during his/her lifetime: __________
Please list other medication your child has taken: ____

Vaccination History:
☐ We have chosen to exercise our right to not to vaccinate our child according to the provision made through the Wisconsin State Statute 252.04, article 3.
☐ Child is up-to-date on state recommended vaccinations.

Prenatal History:

Name of Obstetrician/Midwife: ____
Were there any complications during pregnancy? _____NO _____YES, Please explain: __________
____
Ultrasounds during pregnancy? _____NO _____YES, How many? __________
Medications during pregnancy/delivery? _____NO _____YES, Please list: _____________________
____
Cigarette/Alcohol use during pregnancy? _____NO _____YES
Location of birth: _____Home _____Birthing Center _____Hospital
Birth Intervention: _____Forceps _____Vacuum Extraction
_____Ceasarian Section: ☐ Emergency ☐ Planned ☐ By Choice
Complications during delivery? _____NO _____YES, List: __________________________________
Genetic disorders/disabilities? _____NO _____YES, List: __________________________________
Birth weight: __________ Birth Length: __________
Did your child require any medical intervention at birth? _____NO _____YES, Please explain:
____

Childhood Illness (es): **Check all conditions your child has had. CIRCLE all CURRENT conditions.**

☐ ADD	☐ chicken pox	☐ headaches	☐ scoliosis
☐ atopic dermatitis (eczema)	☐ crohn's/colitis	☐ hepatitis	☐ seizure disorder
☐ allergies/hayfever	☐ depression	☐ HIV	☐ sickle cell anemia
☐ anemia	☐ diabetes	☐ measles	☐ spina bifida
☐ asthma	☐ ear infections	☐ mumps	☐ other:
☐ bedwetting	☐ fetal drug exposure	☐ psoriasis	
☐ cerebral palsy	☐ food allergies (list below)	☐ rash	

Injury (ies):

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.).
Was this the case with your child? _____NO _____YES, Please explain: ________________________________
____

Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____NO _____YES
List: ____

Has your child ever been a passenger involved in a car accident? _____NO _____YES

Has your child been seen by a healthcare professional on an emergency basis? _____NO _____YES
Has your child ever broken a bone? _____NO _____ YES, List: _____________________________________
Has your child had any surgeries (including tubes in ears, tonsillectomy, etc.)? _____ NO _____ YES
Please list: ____
***For Females:* Date of onset of menarche: ____________ ☐ Not applicable**

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
father	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
mother	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
paternal grandfather	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
paternal grandmother	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
maternal grandfather	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
maternal grandmother	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________
brother(s)	☐ alive	☐ deceased	☐ no significant disease	☐ has/had: _____________________
sister(s)	☐ alive	☐ deceased	☐ no significant disease	☐ has/had:______________________

Insurance Information:

Who Is Responsible For Your Child's Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY

☐ Your Spouse ☐ Auto Insurance ☐ Other (be specific):_______________

Personal Health Insurance Carrier: __________________ Health ID Card #: ____________________________

Policy Holder's Name: ______________________________ Group #: _____________________________________

Policy Holder's Social Security #: ______-_____-_______ Primary Care Physician: _______________________

Policy Holder's Date of Birth _________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Frain Family Chiropractic Wellness Center, Ltd. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Frain Family Chiropractic Wellness Center, Ltd., will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Print Patient's Name: ____________________________

I am the parent/legal guardian of the above named patient and have the legal right to consent to care for this child.
Print Guardian's or Parent's Name: _________________________________
Guardian or Parent's Signature Authorizing Care: __________________________________ Date: ______________

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