KING CHIROPRACTIC

Child History

Regarding children: My responsibility as your chiropractor is to examine and evaluate your child's spine for the presence of “vertebral subluxation”. Vertebral subluxations are spinal misalignments that alter nervous system function and limit the full expression of health, growth and normal development).

Child’s name:	Age:	DOB:
Parent/guardian name:		Relationship:
Address:		Zip:
City:		State:
Cell Phone:	Other Phone:	Email:

About the pregnancy/delivery

Did you carry to full term? Y N explain:

Describe any complications with pregnancy/delivery

Difficult Birth? Y N explain:

Baby’s APGAR score at delivery: _____ and at 5 mins _____

Did you breastfeed? Y N How long? What formula after?

Is your child vaccinated? Y N All required Not vaccinated by choice

Any reactions to any vaccinations noticed? Y N (If yes which one and what was noticed?)

Has your child been hospitalized for any reason? Y N (explain on the next line)

Has your child had any fractures, major falls or been in a motor vehicle accident? Y N

Explain:

Has your child been given antibiotics? Y N If yes, for what and for how long?(explain next line)

Is your child taking any medications either over the counter or prescribed? Y N

If yes, explain:

Child History

Injuries, trauma, health issues (please note major recurring issues)

From birth to age 3, did any of the following occur? P = Past C = Currently

Fall from changing table	P C	Frequent crying spells/colic	P C
Tumble down stairs	P C	Frequent fevers	P C
Fall out of crib	P C	Frequent diarrhea	P C
Fall off of playground equipment	P C	Frequent constipation	P C
Played in jolly jumper	P C	Frequent ear infections	P C
Frequent trouble sleeping	P C	Trouble gaining weight	P C
Tonsillitis	P C	Reaction to vaccines	P C
Depression/anxiety	P C	Other:	P C
Stomach/digestive issues	P C	Allergies	P C
Asthma	P C	Upper resp. Infection	P C
Hyperactive/Autism	P C	Chronic Illness	P C

Please explain any of the above:

If your child is adopted, please include any relevant health information here:

Authorizations

I, the undersigned, authorize **Dr. Rhett Kin**g to provide chiropractic care to my minor dependent(s). I am giving written permission for Dr. Rhett King to make the best decisions regarding the chiropractic care my children will receive since I, the parent/legal guardian listed below may not be present at all of his/her schedule visits. I understand that I or another parent/legal guardian will and must be present for my child's first appointment. I also understand this signed consent will be valid until the minor child is 18 years of age, or unless I withdraw this permission in writing. When a child is no longer a minor, this authorization will still be in place unless the child, now an adult, withdraws this permission in writing. I also take knowledge that I have read and understand this office's HIPPA policy document and was offered a copy of it. I realize that I may elect not to keep a copy of it. I attest to the fact that all the information provided on this form is accurate and truthful and that I have read and understand all the stated policies noted in this document. The doctor and I (legal parent/guardian) have adequately discussed the risks involved with treatment that are specific to my child's chiropractic care. I have also provided the above information freely and accurately. I presented my child/children today for no other reason than evaluation and treatment of vertebral subluxation.

Legal guardian name: date:

Legal guardian signature: