Miller Chiropractic Health Center

13470 S. Arapaho, Suite 150 Olathe, KS 66062 (913) 782-7260

CHILD HISTORY FORM - Nutrition

Please answer the questions on this form as completely as possible. If you need assistance, please ask at the front desk, and we will be happy to assist you.

Child's Name: _____ Today's Date: _____
Gender: M F Date of Birth: ____/____/____ Age: _____ SS#: _____
Siblings' Name(s) and Age(s): _____
Street Address: _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
E-mail address: _____
Who referred you to our office? _____
Name of medical doctor: _____
Date and reason for last MD visit: _____

RESPONSIBLE PARTY:
Parent or Guardian Name(s): _____ Date of Birth: _____/_____/_____
Relationship to Patient: _____
Street Address (if different from child's) : _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
E-mail address: _____
Employer Name: _____ Occupation: _____

Authorization for Care of a Minor Child Under 18 Years of Age

I hereby authorize and consent to the nutritional evaluation of my child, _____

Parent(s) _____ Contact Phone #: _____
Parent/Guardian Signature: _____ Date: _____

PRESENT HEALTH COMPLAINTS/CONCERNS

What concerns/health complaints brought your child here today?
Major: _____
Minor: _____
When did this problem begin? _____
Description of onset or injury: _____
Is this problem: □ Occasional □ Frequent/Constant □ Intermittent
What makes this worse? _____
What makes this better? _____
Does the problem interfere with the child's sleep? _____ Eating? _____ Play? _____
Is the child's daily routine affected? _____
Is this becoming worse? _____
Other professionals seen for this condition: _____
Results with any treatment(s): _____
_____

PATIENT: DOB: TODAY'S DATE:

PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

FINANCIAL POLICY/COMMUNICATION POLICY: I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered me will be immediately due and payable. I give Miller Chiropractic Health Center and its representatives permission to communicate to me via the contact information above.

Patient's or authorized person's signature: _____ **Date** _____

I ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, AND UNDERSTAND AND AGREE TO THE *Notice of Privacy Practices* of Miller Chiropractic Office, PA, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

_____ _____

Signature of patient or legal guardian **Date**

I give permission for the following persons to have full access to my medical records:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

NUTRITIONAL INFORMED CONSENT: Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Any suggested nutritional advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I have read and understand the above.

Signature: _____ **Date:** _____

HISTORY OF BIRTH

What was the child's gestational age at birth? _____ weeks Birth weight: _____ lbs. _____ oz. Birth length: _____

Was your child's birth: □ at home □ in a birthing center □ in a hospital Duration of labor and birth: _____ hours

Were there any complications to the delivery? If yes, please explain: _____

_____

Please check any form of assistance that was used during delivery:

□ Forceps □ Vacuum extraction □ Cesarean □ Episiotomy

Was labor: □ spontaneous □ induced APGAR Scoring: at birth _____/10 after 5 minutes _____/10

Were medications or epidurals given to the mother during birth? If yes, what was given? _____

_____

PATIENT: DOB: TODAY'S DATE:

HEALTH HISTORY

Often, seemingly unrelated symptoms can manifest as other health concerns. Please circle if your child has had any of the following:

Headaches	Loss of taste	Weight gain	Upper back pain
Dizziness	Light sensitivity	Dental problems	Neck pain
Fainting	Face flushing	Fevers	Low back pain
Fatigue	Cold sweats	Heart palpitations	Radiating pain
Irritability	Bronchitis	Chest pressure	Stiffness
Depression	Pneumonia	Breast pain	Reduced mobility
Loss of balance	Difficulty breathing	Frequent colds	Numbness in leg(s)
Loss of concentration	Shortness of breath	Sinus congestion	Numbness in foot/feet
Loss of memory	Asthma	Sore throat	Numbness in hand(s)
Ears buzzing/ringing	Urinary problems	Ear pain/infections	Weakness
Poor coordination	Constipation	Allergies	Muscle cramps
Vision changes	Diarrhea	Heart burn	Sleeping problems
Loss of smell	Weight loss	Bloating/gas	Vomiting
Other(s):			

1. Please list any known **health conditions** that your child has been diagnosed with: _____
_____
2. List any **medications** your child is currently taking or has taken in the past: _____
_____
3. Please indicate any history of **antibiotic use,** listing when, what, and for what purpose: _____
_____
4. Are there any known **drug allergies**? _____
5. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:
_____
_____
6. Do you suspect your child to use recreational drugs? _____ If so, what? _____
7. List any hospital procedures/surgeries that your child has had:
_____
_____
_____
8. Please list any illnesses that your child has had and approximate dates of occurrence:
_____
_____
9. Has your child been vaccinated? Yes No Recently? Yes No
10. Please describe any reactions that your child has had to past or recent vaccinations:
_____
11. Did your child have colic as an infant? Yes No
12. How as your child fed as an infant? Breast Bottle Brand of formula? _____
11. Please list any other concerns you have regarding your child's health:
_____
_____

Do you have a family physician? ☐ Yes ☐ No **Physician's name and address:**

Do you wish to grant Miller Chiropractic Health Center physicians permission to share/discuss medical findings with your other healthcare providers (i.e. MD, DO Orthopedist, Surgeon, etc.) if they deem necessary? ☐ Yes ☐ No

PATIENT: TODAY'S DATE:

LIFESTYLE INDICATORS

Please fill in or circle the appropriate answer:

1. Does your child consume any of the following?

Soda	None	< 2 cans/day	> 2 cans/day
Sweets/Carbs	None	< twice/day	>twice/day
White Flour	None	< twice/day	>twice/day
Milk/Dairy Products	None	< twice/day	> twice/day
Juice	None	< twice/day	> twice/day
Meat/Fish	None	< twice/day	> twice/day

2. How much water does your child drink each day? _____
3. Are there smokers in the child's home? Yes No
4. Does your child get consistent physical activity? Yes No
5. Please list any regular exercise activities or sports that your child participates in: _____

_____

Sleep Habits: (please fill in or circle the appropriate answer)

1. How well does your child sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
2. Does your child wake up tired? Yes No
3. How many hours does your child sleep in an average night? _____
4. Does your child take naps? Yes No
5. Does your child have nightmares? No Sometimes Often

FOR CYCLING FEMALES ONLY

FOR CYCLING FEMALES ONLY: (please fill in or circle the appropriate answer)

1. Age of onset of menarche (first period): _____ Approximate Date:_____
2. Is your child currently using any method of birth control? Yes No
   If so, what kind? Oral pill Injected Patch Ring
   How long has your child been using birth control? _____
3. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy/light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue): _____

_____

_____

4. First day of last period: _____ Length of typical period: _____
5. Is menstrual cycle regular? Yes No Not Always
   Details: _____
6. Any knowledge of passing clots? Yes No If so, how often? _____
7. Any spotting between periods? Yes No At what point in cycle? _____
8. Does your child experience cramping? None Mild Moderate Severe
   At what point in the cycle? _____

Doctor's Notes: