HEALTHYLIVING
CHIROPRACTIC & WELLNESS CENTER

1857 Sand Lake Rd. Onalaska, WI 54650
Phone: 608-781-2881
Fax: 608-781-2882
www.hlconalaska.com

Last Name:_____ First Name:_____ Middle Initial:_____
Address:_____
Birthdate:___/___/___ SSN:_____ Gender: Male/ Female
Home Phone:_____ Mother's Mobile:_____ Father's Mobile:_____
Emergency Contact: (Other than parent's mobile)_____ _____
Pediatrician:_____ Date of Last Visit:_____ Reason:_____
Birth Weight:_____ Birth Height: _____ Current Weight:_____ Current Height:_____
Ever Been Under Chiropractic Care: Y / N

CHILD'S CURENT PROBLEM:

Purpose of this visit: ____Wellness ____Check-up ____Other:_____
____ Pain/Discomfort; explain_____
____Injury; explain_____

If due to Pain/ Discomfort/ Injury, please fill out:

1. Onset of Problem: Date___/___/_____ ____Unknown ____Gradual ____Sudden
2. Ever had this problem before? Y / N If yes, when?_____
3. Any bowel or bladder problems since this problem began? No Yes, (describe):_____
4. Any medication taken for this problem? No Yes:_____
5. Have you seen any other doctors for this problem? No Yes:_____
6. How is this problem NOW: ____Rapidly Improving ____Improving Slowly ____About the Same
   ____Gradually Worsening ____On & Off
7. Does anything make this problem better?_____
8. Does anything make this problem worse?_____

PREGNANCY HISTORY:

Third Trimester Presentation: ____Vertex ____ Breech ____ Transverse ____Face/Brow
Type of Birth: ____ Normal Vaginal ____ Forceps ____ Cesarean ____ Suction Vacuum
Location: ____ Home ____ Hospital ____Birthing Center ____Other: _____

Problems during Pregnancy: _____
Problems during Labor/Delivery: _____

Was there presence of: ____Jaundice? (Yellow) ____Cyanosis? (Blue) ____Congenital Anomalies/Defects?
*If yes, please explain*_____

INFANT HISTORY:

Infant feeding: ____Breast ____Formula If formula, which one?_____
Number of hours per sleep per night_____ Quality of Sleep: ____Good ____Fair ____Poor
List **ALL** immunizations your child has had_____
_____

Has your child ever been treated at the emergency room? Y / N If yes; please explain_____
Has your child ever been hospitalized? Y / N If yes; please explain_____
Has your child ever had any Surgeries? Y / N If yes; please explain_____
Current Medications/Supplements_____

AT WHAT AGE DID THE CHILD:

Respond to Sound_____ Follow an object with his/her eyes_____ Hold head up_____
Sit Alone____ Crawl____ Stand____ Walk alone____

AT WHAT AGE, IF EVER, DID THE CHILD SUFFER FROM THE FOLLOWING:

Chicken pox____ Mumps____ Measles____ Rubella____
Whooping Cough____ Other:_____

PLEASE CIRCLE IF YOUR CHILD HAS EVER SUFFERED FROM:

Headaches	Orthopedic Problems	Digestive Issues	Behavioral Problems
Dizziness	Neck Problems	Poor Appetite	ADD/ADHD
Fainting	Arm Problems	Stomach Aches	Ruptures/Hernias
Seizures/Convulsions	Leg Problems	Reflux	Muscle Pain
Heart Trouble	Joint Problems	Constipation	Growing Pains
Chronic Earaches	Backaches	Diarrhea	Allergies to _____
Sinus Trouble	Poor Posture	Hypertension	Allergies to _____
Asthma	Scoliosis	Anemia	Allergies to _____
Colds/Flu	Walking Trouble	Bed Wetting	Other:_____
Colic	Broken Bones	Sleeping Problems	Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

Fall in baby walker	Fall from bed or couch	Fall off skateboard or skates
Fall from crib	Fall off swing	Fall off bicycle
Fall from high chair	Fall off slide	Fall down stairs
Fall from changing table	Fall off monkey bars	Other:_____

Has your child ever sustained an injury playing organized sports? Y / N If yes; please explain_____
_____

Has your child ever sustained an injury in an auto accident? Y / N If yes; please explain_____
_____

FAMILY HISTORY

Please indicate if you child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____Heart Disease ____Diabetes ____Stroke ____Cancer ____Asthma

____Stroke ____High blood pressure ____Low blood pressure

____Gastrointestinal disease ____Memory/ mood disorder ____Thyroid problem

Please Initial (Guardian)

_____I Instruct the Chiropractor to deliver the care that, in his or her best judgment, can help my child in the restoration of his/her health. I also understand the Chiropractic Care delivered in this office is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letter, or e-mails or health information to my child as an extension to my care in this office.

_____I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services my child receives.

_____To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my child's health concern.

Printed Name (Guardian)_____

Signature (Guardian)_____ Date:_____

We appreciate your patience in filling out the necessary paperwork!

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