CHILD'S HEALTH HISTORY

Today's Date _____

CHILD'S PERSONAL INFO

Name _____ Date of Birth _____ Gender _____
Address _____ City _____ State _____
Names & Ages of Siblings _____

Parent A	Parent B
Name _____	Name _____
Home Phone _____	Home Phone _____
Cell Phone _____	Cell Phone _____
Employer _____	Employer _____
Email _____	Email _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel All Bright Chiropractic can address for your child?
_____
_____
_____

Are these concerns affecting your child's quality of life?

School	□N □Y	Exercise/ Sports	□N □Y	Walking	□N □Y
Playing	□N □Y	Sleep	□N □Y	Attention/ Focus	□N □Y
Communication	□N □Y	Eating	□N □Y	Daily Routine	□N □Y

I would like my child to experience the following benefits from Chiropractic Care: (Check all that apply)
□Relief of a symptom or problem
□Relief and prevention of a symptom or problem
□Healthier spine and nerve system
□Optimal health on all levels

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? □N □Y
Have you consulted or do you regularly consult any of the following providers for your child?

□ Medical Doctor	□ Naturopath	□ Acupuncturist	□ Homeopath
□ Massage Therapist	□ Counselor	□ Energy Healer	□ Dentist

Reason:
_____
_____

HEALTH, VITALITY, & CHIROPRACTIC CARE

The primary system in the body which coordinates health is the **nerve system**. The vertebrae bones of the spinal column surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called **vertebral subluxation**. Vertebral subluxation results in nerve malfunction due to vertebral/ spinal misalignment. Spinal subluxations can have physical, emotions, and chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, and CHEMICAL stressors your child has been subjected to in, how they may relate to his/ her present spinal nerve and health status, and whether they may have played a part in creating vertebral subluxations.

PREGNANCY & BIRTH

The birth process can be traumatic to a baby's spine and cause interference to the nervous system.

During pregnancy did the mother:

Experience any illnesses, difficulties, or trauma? ☐N ☐ Y List: _____
Take any drugs/medications? ☐N ☐ Y List: _____
Smoke or consume alcohol? ☐N ☐ Y List: _____

How many weeks was Baby at delivery? _____ Weight: _____
Approximately how long did labor last? _____ hours
Was the child in a breech position (butt down) or otherwise constrained? ☐N ☐ Y

Please check where the child was born & if any of the following were administered during labor and birth.

☐ Home Birth	☐ Hospital Birth	☐ Birth Center	☐ Epidural
☐ Pitocin	☐ Vacuum	☐ Forceps	☐ Caesarean
☐ Vaginal	☐ Episiotomy	☐ Manual Traction of Neck	☐ Medications

What was the child's APGAR Score? _____
Was the baby breastfed? ☐N ☐ Y For how long? _____

Physical Stress

- □ Uncoordinated/ Accident Prone
- □ Hospitalization
- □ Severe Trauma/ Concussion
- □ Automobile Accident
- □ Bone Fracture/ Joint Dislocation
- □ Chronic Illness
- □ Surgery
- □ Carrying Heavy Bookbag
- □ Poor/ Not Enough Sleep

Emotional Stress

- □ Academic Pressure
- □ Lifestyle Change
- □ Loss of a Loved One
- □ Parents' Divorce
- □ Made Fun of/ Bullied
- □ Loss of Pet
- □ Relocation
- □ Body Image Issues
- □ Hard to Interact with Others

Chemical Stress

- □ Vaccinations
- □ Reactions to Vaccines
- □ Environment (i.e. Poor Air/ Water)
- □ Second Hand Smoke
- □ High Sugar Consumption
- □ Poor Diet
- □ Soda Pop
- □ Antibiotics
- □ Prescription/ OTC Drugs (list below)

Please list any prescription or over-the-counter medications your child takes_____
_____
Please list any supplements or vitamins your child takes_____
_____
How much water does your child drink daily? _____
What physical activities does your child participate in? _____
Does your child have allergies or sensitivities to any foods? □N □Y _____

FINANCES

Payment in full is expected on all FIRST VISIT services.

First Visit Fee: Comprehensive Exam $100 Adjustment (if appropriate) $50

Our Unique Approach to Finances at ABC

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. We utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary (as determined by your chiropractic evaluation) at affordable fees

Insurance

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will happily provide you with itemized monthly statements for you to submit

The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give Dr. Marqelle Albrecht permission to render care to my child today.

Name (printed) _____ Date _____
Signature _____

CONSENT FORM

PLEASE READ AND SIGN

1. A copy of All Bright Chiropractic's Notice of Privacy Practices for Protected Health Information (HIPAA) is available for my review in the office.

2. I understand that care is given in an open setting. A private room may be available upon request but is not guaranteed.

3. I consent to receive communication from ABC in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.

4. I consent to my child's testimonial being used in office and electronically with my first name and last initial only. If I should withdraw my consent, I will notify the office in writing.

5. I consent to my and my child's photo or image being used in photograph or video in public media including social media, website, and other promotional materials. If I should withdraw my consent, I will notify the office in writing.

6. I agree that I am responsible to pay for all services my child receives in this office.

Name (printed) _____ Date _____
Parent or Guardian's Name (printed) _____
Signature _____

Please note below any withdrawal of consent to any of the above statements:

Signature _____ Date _____

Welcome to All Bright Chiropractic!

DR. MARQELLE ALBRECHT

701.297.8191 1121 WESTRAC DR. SUITE 102 FARGO, ND 58103