280 US Highway 9, Morganville, NJ 07751
www.GetWellNJ.com
(732) 617-9355

Upper Cervical Chiropractic
of Monmouth, LLC

Confidential Health Record — Pediatric

Welcome To Our Office! Today's Date M/D/Y ___/___/___

How did you hear about us? _____

Child's Name LAST _____ FIRST _____ MIDDLE _____

Birth Date M/D/Y ___/___/___ Age _____ Current Height _____ Current Weight _____ # of Siblings _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Parent Name _____ CELL _____ Social Security # ___-___-___

Parent Name _____ CELL _____ Social Security # ___-___-___

Pediatrician/Family MD _____ Last Visit M/D/Y ___/___/___

Present Health Challenge

Purpose of Visit PLEASE CHECK ○ Wellness Check-up ○ Injury or Accident ○ Other: _____

Has it ever occurred before? ○ Yes ○ No

When do you think these problems originally started? _____

Have you seen any other doctors for this problem? ○ Yes ○ No

If yes, when? M/D/Y ___/___/___ who? _____

What were the results of past treatment? _____

How is this problem now? PLEASE CHECK ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ On & Off ○ Gradually Worsening

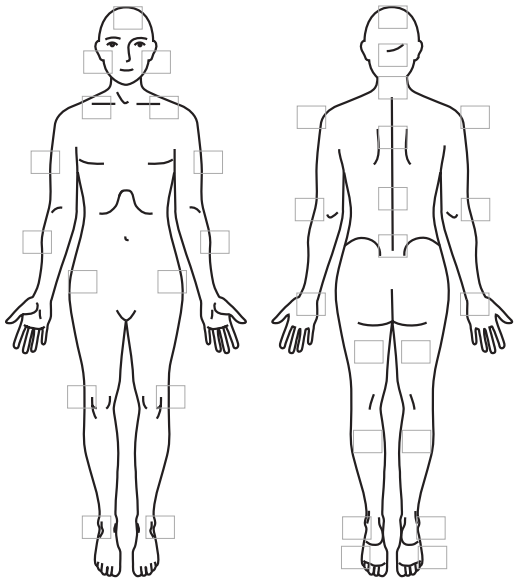
Please list all medications _____

Please list all surgeries _____

Has your child ever sustained an injury playing sports? ○ Yes ○ No If yes, explain _____

Has your child ever sustained an injury in an auto accident? ○ Yes ○ No If yes, explain _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



What makes the pain worse? _____

What makes the pain better? _____

Lifestyle Review

1. On a scale of Poor, Good, Excellent please describe their lifestyle MARK **POOR**, **GOOD** OR **EXCELLENT**.
   Diet _____ Exercise _____ Sleep _____ General Health _____
2. What Wellness services/products do you currently incorporate into their lifestyle? _____
3. What Supplements are they currently taking? _____
4. Have they ever had Chiropractic care? ○ Yes ○ No If yes, doctor's name _____
5. What would you like to gain for your child from chiropractic care? _____

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Level of Impairment Due to Symptoms CHECK THE APPROPRIATE LEVEL WITH **0 = NONE / 10 = EXTREME**

While Resting	○0	○1	○2	○3	○4	○5	○6	○7	○8	○9	○10
With Activity	○0	○1	○2	○3	○4	○5	○6	○7	○8	○9	○10

Daily Activities – Effects of Current Condition on Performance. PLEASE CHECK THE APPROPRIATE CIRCLE

Bending	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Change Position (Sit-Stand)	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Climb Stairs	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Playing Sports	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Doing Chores	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Carrying/Lifting	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Reading/Concentration	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Self Care (Bathe/Dress)	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Sleeping	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Prolonged Sitting	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Prolonged Standing	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)
Walking	○No Effect	○Mild (Can do)	○Moderate (Limited)	○Severe (Unable to Perform)

REVIEW OF SYSTEMS **Has your child ever suffered from:** PLEASE CHECK THE ITEMS BELOW THAT APPLY TO YOUR CHILD

Nervous System

○Dizziness	○Loss of Balance	○Numbness	○Tremor	○Seizures/Convulsions
○Headaches	○ADD/ADHD	○Stress	○Sleeping Problems	○Bedwetting

Cardiopulmonary

○Asthma	○Sinus Problems	○Colds/Flu	○Heart Problems	○Hypertension

Physical

○Orthopedic Problems	○Poor Posture	○Growing Pains	○Scoliosis	○Joint Problems
○Walking Trouble	○Broken Bones	○Backaches	○Earaches	○Ruptures/Hernia
○Arm Problems	○Neck Problems	○Leg Problems	○Muscle Pain	○Serious Fall

Gastrointestinal

○Stomach Ache	○Anemia	○Indigestion/Colic	○Diarrhea/Constipation	○Difficulty Swallowing

Psychological

○Behavioral Problems	○Depression	○Anxiety	○Bi-Polar Disorder	○Loss or Change in Appetite

Immune

○Itching	○Anaphalaxis	○Rash	○Food Intolerance	○Allergies

I understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any disease or entity.
The risks associated with exposure to x-rays have been explained to me to my complete satisfaction, and after careful consideration, I hereby authorize imaging studies and chiropractic care for the benefit of my minor child on behalf of whom I have the legal right to select and authorize health care services. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

By signing, I agree the statements made on this form are complete and truthful to the best of my recollection and I knowingly allow UCC of Monmouth to examine my child for evaluation/treatment, and understand that I am responsible for all charges incurred.

Parent/Guardian Name _____ **Signature** _____

Email _____ **Date** M/D/Y ___/___/___