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 _____

_____

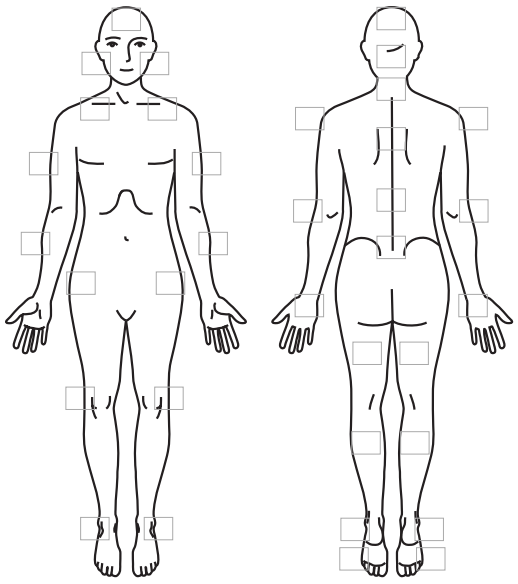
Has your child ever sustained an injury playing sports? ○ Yes ○ No If yes, explain _____

_____

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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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, explain _____

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, list them _____

Other, explain _____

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 ___/___/___