Rockwall Health Center
2880 Ridge Rd
Rockwall, TX 75032
(469) 769-1009

YOUNG ADULT PATIENT HEALTH RECORD

PATIENT NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	WEIGHT:

PARENTS/LEGAL GUARDIANS NAMES:	
ARE YOU THE PARENT OR LEGAL GUARDIAN: ☐ PARENT ☐ GUARDIAN	
MARITIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPERATED ☐ DIVORCED	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (LIST ALL THAT APPLY) ☐ ONLINE ☐ SIGN ☐ YELLOW PAGES ☐ COMMINITY EVENT ☐ MAILING
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR? ☐ YES ☐ NO

NUMBER OF DOSES OF PRESCRIPTION MEDICATION CHILD HAS TAKEN DURING HIS/HER LIFETIME:

PLEASE LIST ALL MEDICATIONS:

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD?

☐ YES ☐ NO

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:

☐ DPT ☐ MMR ☐ CHICKEN POX ☐ HEPATITIS ☐ OTHER

DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S):

DESCRIBE THE REASON FOR THIS VISIT:

☐ WELLNESS ☐ CONDITION

IF CONDITION, DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY ☐ OTHER

PLEASE EXPLAIN:

WHEN DID THIS CONDITION BEGIN:

HAS THIS CONDITION:

☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ COME AND GO

DOES THIS CONDITION INTERFERE WITH:

☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?

☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?

☐ YES ☐ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.*

- ☐ ACID REFLUX
- ☐ ANXIETY
- ☐ ASTHMA
- ☐ BACK PAIN/STIFFNESS
- ☐ BED WETTING
- ☐ BRONCHITIS
- ☐ COLIC
- ☐ HEADACHES
- ☐ HYPERACTIVITY
- ☐ HIPS/KNEE/ANKLES
- ☐ LEARNING DISORDERS
- ☐ NECK STIFFNESS/PAIN
- ☐ NERVOUSNESS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ DEPRESSION
- ☐ DIFFICULT/PAINFUL/IRREGULAR PERIODS
- ☐ DIFFICULT WEIGHT GAIN
- ☐ EAR INFECTIONS
- ☐ FREQUENT COLDS, COUGHS, ETC.
- ☐ SHOULDERS/ELBOW/WRIST
- ☐ SLEEPING PROBLEMS
- ☐ SORE THROAT
- ☐ STRESS
- ☐ UPSET STOMACH
- ☐ URINARY INFECTIONS

DURING PREGNANCY DID YOU USE:

☐ DRUGS/MEDICATIONS ☐ TOBACCO/ALCOHOL

IF YES, PLEASE LIST:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?

☐ YES ☐ NO

PLEASE EXPLAIN:

ULTRASOUND DURING PREGNANCY?

☐ YES ☐ NO NUMBER:

LOCATION OF BIRTH:

☐ HOME ☐ BIRTHING CENTER ☐ HOSTIPAL

DESCRIBE YOUR DELIVERY:

- ☐ LABOR WAS CHEMICALLY INDUCED
- ☐ LABOR WAS DOCTOR ASSISTED
- ☐ C-SECTION DELIVERY
- ☐ FORCEPTS/VACUUM EXTRACTION
- ☐ DOCTOR PULLED OR TWISTED BABY
- ☐ PREMATURE DELIVERY

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT: _____

BIRTH LENGTH: _____

APGAR SCORES: _____

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

DID YOU BREASTFEED THE BABY?

☐ YES ☐ NO

IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY?

☐ YES ☐ NO

IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS: _____

COW'S MILK: _____

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

☐ YES ☐ NO

DOES YOUR CHLD EXERCISE DAILY?

☐ YES ☐ NO

HOW MUCH?

DOES YOUR CHILD DRINK SODA?

☐ YES ☐ NO

HOW MUCH?

DOES YOUR CHILD TAKE VITAMINS?

☐ YES ☐ NO

DOES YOUR CHILD DO AFFIRMATIONS?

☐ YES ☐ NO

DOES YOUR CHILD HAVE DIFFICULTY SLEEPING?

☐ YES ☐ NO

EXPLAIN:

DOES YOUR CHILD PLAY VIDEO GAMES?

☐ YES ☐ NO

HOW MUCH?

DOES YOUR CHILD WATCH MORE THAN AN HOUR OF TV PER DAY?

☐ YES ☐ NO

HOW MUCH?

DOES YOUR CHILD EAT BALANCED MEALS?

☐ YES ☐ NO

DOES YOUR CHILD EXPERIENCE PROLONGED SADNESS?

☐ YES ☐ NO

EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E. BED, CHANGING TABLE, STAIRS, ETC).

WAS THIS THE CASE FOR YOUR CHILD?

☐ YES ☐ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?

☐ YES ☐ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?

☐ YES ☐ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

☐ YES ☐ NO

PLEASE EXPLAIN:

PLEASE RATE STRESS LEVEL ON A SCALE OF 1-10 (10 BEING HIGH)

SCHOOL: 1 2 3 4 5 6 7 8 9 10

PERSONAL: 1 2 3 4 5 6 7 8 9 10

AUTHORIZATION FOR CARE OF A MINOR

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing. I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care. To work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered will become immediately due and payable.

PARENT OR GUARDIAN SIGNITURE: DATE: