Child Member Health Record

ABOUT THE CHILD

Name:

Mailing Address:

City: State/Zip

Phone:

Date of Birth: Age:

Social Security Number:

Gender: Weight:

ABOUT THE PARENT

Parent Name:

Address:

☐ Same as above

City: State/Zip

Home Phone: Cell Phone:

Email Address:

Employer Name:

Employer Address:

Employer City: Employer State/Zip

Work Phone: Position/Title

VACCINATIONS

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):

CHIROPRACTIC EXPERIENCE

Who Referred You To Our Office?

Have You Been Adjusted By A Chiropractor Before?

If Yes, What Was The Reason For Those Visits?

Doctor's Name:

Approximate Date Of Last Visit:

Has Anyone In Your Family Ever Seen A Chiropractor?

REASON FOR THIS VISIT

Describe The Reason For This Visit:

Is The Purpose Of This Appointment Related To:

☐ Job ☐ Sports ☐ Auto ☐ Fall
☐ Chronic Discomfort ☐ Other

Please Explain:

When Did This Condition Begin?

Has This Condition:

☐ Gotten Worse ☐ Stayed The Same ☐ Come & Go

Does This Condition Interfere With:

☐ Daily Routine ☐ Sleep ☐ Other Activities

Please Explain:

Has This Condition Occurred Before? ☐ Yes ☐ No

Please Explain:

Have You Seen Other Doctors For This Condition?

☐ Yes ☐ No

Doctors Name:

Type Of Treatment:

Results:

MOTHER'S PREGNANCY & LABOR

During Pregnancy Did You Use:

☐ Drugs/Medications ☐ Tobacco/Alcohol

If Yes, Please Explain:

Describe Your Delivery:

- ☐ Labor Was Chemically Induced
- ☐ C-Section Delivery
- ☐ Doctor Pulled or Twisted Baby
- ☐ Forceps/Vacuum Extraction
- ☐ Premature Delivery

Did You Experience Any Illness(s) While Pregnant?

☐ Yes ☐ No

Explain:

Did You Nurse The Baby?

Did Your Baby Have Colic?

CHILDS HEALTH HISTORY

☐ Allergies	☐ Constipation	☐ Irritability
☐ Attention Problems	☐ Digestive Problems	☐ Sleeping Disorders
☐ Asthma	☐ Ear Problems	☐ Skin Problems
☐ Bed Wetting	☐ Frequent Colds	☐ Tubes In Ears
☐ Breathing Issues	☐ Headaches	☐ Vision Problems
☐ Colic	☐ Hyperactivity	☐ Other:

CHILD'S CURRENT HEALTH STATUS

Has Your Child Ever Taken Antibiotics? ☐ Yes ☐ No

Please Explain:

Has Your Child Ever Been Hospitalized? ☐ Yes ☐ No

Please Explain:

Has Your Child Ever Had A Severe Fall? ☐ Yes ☐ No

Please Explain:

Has Your Child Ever Been In An Accident? ☐ Yes ☐ No

Please Explain:

Is Your Child Accident Prone? ☐ Yes ☐ No

Please Explain:

Has Your Child Ever Had Surgery? ☐ Yes ☐ No

Please Explain:

Is Your Child Currently On Medication? ☐ Yes ☐ No

Please List:

Does Your Child Have Difficulty Interacting With Others?

☐ Yes ☐ No Please Explain:

What Changes (If Any) In Your Child's Health Or Behavior Would You Like Accomplished?

CHIROPRACTIC AWARENESS

WERE YOU AWARE THAT...

Doctors Of Chiropractic Work With The Nervous System? ☐ Yes ☐ No	The Nervous System Controls All Bodily Functions And Systems? ☐ Yes ☐ No
Chiropractic Is The Largest Natural Healing Profession In The World? ☐ Yes ☐ No	If Chiropractic Care Starts At Birth, You Can Achieve A Higher Level Of Health Throughout Life? ☐ Yes ☐ No

AUTHORIZATION FOR CARE OF A MINOR

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 me that are not covered by my insurance 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 Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I also understand that all co-pays and non covered services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of you r records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Print):	Relationship To Patient:
Signature:	Date:

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic Care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic Spinal Evaluation, we encounter Non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature:	Date: