PATIENT HEALTH RECORD-CHILD

ABOUT THE CHILD

Name_____

Address_____

City_____ State_____

Zip _____Home phone _____

Birth date _____

Age _____ Gender _____ Weight _____

Social Security # _____

ABOUT THE PARENT

Name _____

Employer _____

Work Phone_____

Type of Work_____

Birthdate:_____Marital Status:_____

SS# _____-_____-_____

E-Mail Address_____

How may we reach you ? (Check all that apply)

Home ☐ Work ☐ Cell ☐

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_____

Have you seen or heard about us in/on: ☐ Paper ☐ Sign ☐ YP

Reason for those visits? _____

Doctor's name:_____

Approximate date of last visit:_____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

ABOUT THE INSURED

Name of Insured:_____

Insured SS #_____

Date of Birth _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

☐ Sports ☐ Auto ☐ ☐ Wellness Fall

☐ Home Injury ☐ Ear Infections ☐ Other

Please explain _____

When did this condition begin? _____

Has this condition:

☐ gotten worse ☐ stayed constant ☐ comes and goes

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 for this condition? ☐ Yes ☐ No

Doctor's Name (s) _____

Type of treatment _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

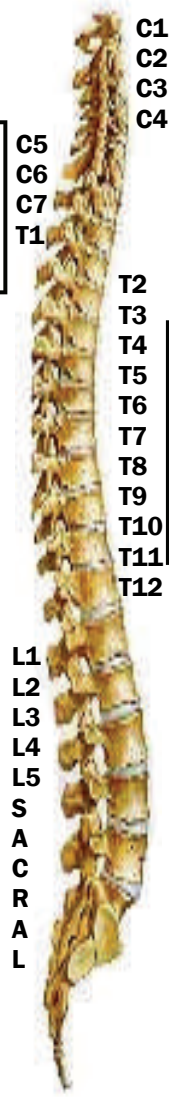
Were you aware that…	**No**	**Yes**
• Doctors of Chiropractic work with the nervous system	☐	☐
• The nervous system controls all bodily functions & systems.	☐	☐
• Chiropractic is the largest natural healing profession in the world?	☐	☐
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐	☐

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has 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.

☐ **Allergies** ☐ **Asthma** ☐ **Attention Problems** ☐ **Bed Wet-** ☐ **ting Colic**
☐ **Breathing Problems** ☐ **Constipation** ☐ **Digestive Problems** ☐ **Ear Problems**
☐ **Frequent** ☐ **colds** ☐ **Headaches** ☐ **Hyperactivity Irritability**
☐ **Skin Problems** ☐ **Sleeping Disorders** ☐ **Tubes in the ears** ☐ **Vision Problems**
☐ **Other**_____

Please circle the health concern or concerns you may be experiencing now or have experienced in the past. Each area of concern relates to an area of the spine and nerve function.



Headaches
Migraines - Dizziness
Sinus Problems -Allergies
Fatigue - Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Sore Throat - Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma –Allergies
High Blood Pressure
Heart Conditions

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis - Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers - Gastritis
Kidney Problems

Constipation - Colitis
Diarrhea - Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

Other:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GOALS FOR MY CHILDS CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief care** – Symptomatic relief of pain or discomfort
☐ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptom
☐ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
☐ **I want the Doctor to select the type of care appropriate for my child's condition.**

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

☐ Drugs/ Medicine ☐ Tobacco/ Alcohol

Please explain_____

Any illness during your pregnancy?_____

_____

How was your delivery?

☐ Labor chemically induced ☐ Labor was Dr. assisted
☐ C-Section delivery ☐ Forceps/ Vacuum extraction
☐ Did Dr. pull or twist baby? ☐ Premature delivery

Please explain:_____

Did you nurse the baby? ☐ Yes ☐ No Colic? ☐ Yes ☐ No

Feeding Problems? ☐ Yes ☐ No Vaccinations? ☐ Yes ☐ No

CHILD'S CURRENT HEALTH STATUS

Has your child ever:	**No**	**Yes**	**If Yes, please explain**
…..taken antibiotics?	☐	☐	_____
…..been hospitalized?	☐	☐	_____
…..had a severe fall?	☐	☐	_____
…..been in a car accident?	☐	☐	_____
Is you child			
…..accident prone?	☐	☐	_____
Had Surgery? Please explain….	☐	☐	_____
…..currently taking any medication(s)?	☐	☐	_____
…..having difficulty interacting with others?	☐	☐	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits a rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished?

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me 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 that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

_____ _____

Signature Date

_____ _____

Guardian's Signature Authorizing Care (If patient is under 18 years of age) Date

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

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 important that each patient understand both the objective and the method that 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 optimal 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.

Patient's / Guardian 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 your 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 it's staff.

I understand that, under the under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 physicians 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:_____

FOR DOCTOR USE ONLY

Patient Case History

Chief Concerns:_____
_____
_____
_____

History of Condition:_____
_____
_____

Associated Symptoms:_____
_____

Aggravating Factors:_____
_____
_____

What has been done to help this condition?_____
_____
_____
_____

Prior Illness, Surgery, Accidents: _____
_____
_____

Family Health History:_____
_____

Other:_____
Dr signature_____