Date: _____

CHILD MEMBER HEALTH RECORD

ABOUT THE CHILD

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

ABOUT THE PARENT

PARENT:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	ZIP CODE:
EMPLOYER CITY:	
WORK PHONE:	POSTION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH:	

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):

Inver Grove chiropractic

2940 65th St. E.
Inver Grove Heights, MN 55076
651-451-1012
651-453-1543 (FAX)

CHILD CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): ___NEWSPAPER ___SIGN ___YELLOW PAGES ___MAILING ___COMMUNITY EVENT ___OTHER_____
HAVE YOU BEEN ADJUSTD BY A CHIROPRACTOR BEFORE? ___YES ___NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMNT RELATED TO : ___SPORTS ___AUTO ___FALL ___HOME INJURY ___OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN:
HAS THIS CONDITION: ___GOTTEN WORSE ___STAYED CONSTANT ___COME AND GONE
DOES THIS CONDITNION INTERFERE WITH : ___SLEEP ___DAIY ROUTINE ___OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? ___YES ___NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDIDTION: ___YES ___NO
DOCTOR'S 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 ___FORCEPS/VACCUM
___PREMATURE DELIVERY ___C-SECTION DELIVERY
___LABOR WAS DOCTOR ASSISTED
___DOCTOR PULLED OR TWISTED THE BABY

PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT:

DID YOU NURSE YOUR BABY?	___YES ___NO
DID YOU EXPERIENCE FEEDING PROBLEMS?	___YES ___NO
DID YOUR BABY HAVE COLIC?	___YES ___NO
VACCINATIONS?	___YES ___NO

INSTRUCTIONS: *Please check each of the disease 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 oval diagnosis, care plan and the possibility of being accepted for care.*

___ALLERGIES	___CONSITPATION	___IRRITABLILITY
___ASTHMA	___DIGESTIVE PROBLEMS	___SKIN PROBLEMS
___ATTENTION PROBLEMS	___EAR PROBLEMS	___SLEEP DISORDERS
___BED WETTING	___HEADACHES	___VISION PROBLEMS
___BREATHING PROBLEMS	___FREQUENT COLDS	___TUBES IN THE EARS
___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 A CAR 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 TAKING MEDICATIONS? ___YES ___NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICUTLY INTERACCTING 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:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHVIOR WOULD YOU LIKE ACCMOMPLISHED?

CHIROPRACTIC AWARENESS

DOCTORS OF CHIOPRACTIC 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 ACHEIVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ___YES ___NO

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assitant to adminster chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered by my child 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. Dr. Crain will not be held responsible for any pre-existing medically daiganosed conditon or for any medical diagnosis. I also understand if I susupend or teminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Inver Grove Chiropractic, P.A. directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.
NAME OF CHILD:_____ BIRTHDATE:_____

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 disclosure for the proposes of treatment, payment, or practice parathion 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 its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain right 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 or disclosed.

PATIENT NAME (PLEASE 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 understand 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 subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual finding, 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 question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE: