

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 address _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

Driver's License # _____

Insured date of birth _____

E-mail address _____

Payment method Cash Check Credit card

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).

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

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

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to

Sports Auto Fall Home Injury
 Chronic Discomfort 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

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

Yes No

- Doctors of Chiropractic work with the nervous system?
- The nervous system controls all bodily functions and 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?

MOTHER'S PREGNANCY & LABOR

Pregnancy

- Full Term
- Premature _____ weeks
- Drugs or Medication during pregnancy
Complications? _____

Labor

- Vaginal Delivery
- Cesarean Section
- Forceps
- Vacuum
- Drugs During Labor

Hours of Labor _____

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.

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Tubes in the ears |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Other _____ |

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever: ...taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child ...accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...currently taking any medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...having difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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

AUTHORIZATION TO CARE FOR A MINOR CHILD

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 you needs and desires when recommending you treatment 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 symptoms
- 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 condition.

Parent or legal guardian's name (print)

Patient's name (print)

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 doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

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 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: _____