

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	<input type="checkbox"/>	<input type="checkbox"/>
• The nervous system controls all bodily functions & systems.	<input type="checkbox"/>	<input type="checkbox"/>
• Chiropractic is the largest natural healing profession in the world?	<input type="checkbox"/>	<input type="checkbox"/>
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	<input type="checkbox"/>	<input type="checkbox"/>

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.

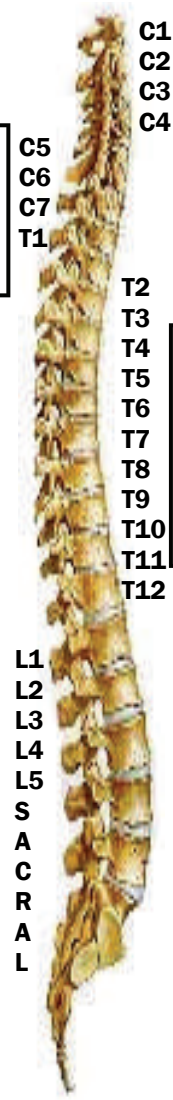
- Allergies
- Asthma
- Attention Problems
- Bed Wetting
- Colic
- Breathing Problems
- Constipation
- Digestive Problems
- Ear Problems
- Frequent colds
- Headaches
- Hyperactivity Irritability
- Skin Problems
- Sleeping Disorders
- Tubes in the ears
- Vision Problems
- Other _____

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.

- C1 Headaches
- C2 Migraines - Dizziness
- C3 Sinus Problems -Allergies
- C4 Fatigue - Head Colds
- Vision Problems
- Difficulty Concentrating
- Hearing Problems

- C5 Sore Throat - Stiff Neck
- C6 Radiating Arm Pain
- C7 Hand/Finger Numbness
- T1 Asthma -Allergies
- High Blood Pressure
- Heart Conditions

- T2 Middle Back Pain
- T3 Congestion
- T4 Difficulty Breathing
- T5 Bronchitis - Pneumonia
- T6 Gallbladder Conditions
- T7 Stomach Problems
- T8 Ulcers - Gastritis
- T9 Kidney Problems
- T10
- T11
- T12



- 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

- L1 Constipation - Colitis
- L2 Diarrhea - Gas Pain
- L3 Irritable Bowel
- L4 Bladder Problems
- L5 Menstrual Problems
- S Low Back Pain
- A Pain or Numbness in legs
- C Reproductive Problems
- R
- A
- L

CHILD'S CURRENT HEALTH STATUS

Has your child ever:

- | | No | Yes | If Yes, please explain |
|------------------------------|--------------------------|--------------------------|------------------------|
|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 you child

- | | | | |
|---|--------------------------|--------------------------|-------|
|accident prone? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had Surgery? Please explain.... | <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 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 _____