CHILD HEALTH RECORD

ABOUT THE CHILD

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

ABOUT THE PARENT

PARENT NAME:	
ADDRESS: □ SAME AS ABOVE	
CITY:	STATE/ZIP:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
OCCUPATION:	
EMPLOYER CITY:	STATE:
WORK PHONE:	

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

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (√ ALL THE APPLY): □ SIGN □ WEBSITE □ EVENT □ PHONE BOOK □ NEWSPAPER □ MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? □ YES □ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATED 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 APPOINTMENT RELATED TO: □ WELLNESS □ 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 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:
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 □ LABOR WAS DOCTOR ASSISTED

□ C-SECTION DELIVERY □ FORCEPS/VACUUM EXTRACTION

□ DOCTOR PULLED OR TWISTED BABY □ PREMATURE DELIVERY

PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(ES) WHILE PREGNANT?

□ YES □ NO

PLEASE EXPLAIN:

DID YOU NURSE THE BABY?	□ YES	□ NO
DID YOU EXPERIENCE FEEDING PROBLEMS?	□ YES	□ NO
DID YOUR BABY HAVE COLIC?	□ YES	□ NO
VACCINATIONS?	□ YES	□ NO

CHILD'S HEALTH HISTORY

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

□ ALLERGIES	□ CONSTIPATION	□ IRRITABILITY
□ ASTHMA	□ DIGESTIVE PROBLEMS	□ SKIN PROBLEMS
□ ATTENTION PROBLEMS	□ EAR PROBLEMS	□ SLEEPING DISORDERS
□ BED WETTING	□ FREQUENT COLDS	□ TUBES IN THE EARS
□ BREATHING PROBLEMS	□ HEADACHES	□ VISION PROBLEMS
□ COLIC	□ HYPERACTIVITY	□ OTHER:

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? PLEASE EXPLAIN:	□ YES	□ NO
HAS YOUR CHILD EVER BEEN HOSPITALIZED? PLEASE EXPLAIN:	□ YES	□ NO
HAS YOUR CHILD EVER HAD A SEVERE FALL? PLEASE EXPLAIN:	□ YES	□ NO
HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? PLEASE EXPLAIN:	□ YES	□ NO
IS YOUR CHILD ACCIDENT PRONE? PLEASE EXPLAIN:	□ YES	□ NO
HAS YOUR CHILD EVER HAD SURGERY? PLEASE EXPLAIN:	□ YES	□ NO
IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? PLEASE EXPLAIN:	□ YES	□ NO

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING 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 BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the Doctor 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 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 if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

TERMS OF ACCEPTANCE

When a person seeks chiropractic care, it is essential that both the doctor and patient be working towards the same objectives. Chiropractic has only one goal that is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine) which interfere with the function of these nerve pathways are called **vertebral subluxations**. Subluxations are caused by many of the things you do **every day** and keep your **whole** body from functioning properly. It is our absolute conviction that the **body is always better off without this interference.**

Consequently, the objective of this office is to provide chiropractic adjustments to correct subluxations thereby restoring normal nerve function. **With a proper nerve supply your whole body is better able to reach its full potential and to express more life.**

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*

Initials

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, announcement and to inform you about our practice and its 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 & direct my care and follow up with multiple healthcare providers who may be involved in that care directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessment 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.*

Initials

PATIENT NAME (PLEASE PRINT)	RELATIONSHIP TO PATIENT
SIGNATURE	DATE