

# CHILD MEMBER HEALTH RECORD

## ABOUT THE CHILD

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

## ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ARE YOU THE PARENT OR LEGAL GUARDIAN: <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO

## MEDICATIONS/VACCINATIONS

NUMBER OF DOSES OF PRESCRIPTION MEDICATION CHILD HAS TAKEN DURING HIS/HER LIFETIME:
PLEASE LIST ALL MEDICATIONS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> WELLNESS <input type="checkbox"/> CONDITION
IF CONDITION, DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTOR FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

**COMPLETE THIS PAGE FOR CHILDREN INFANT TO 5 YEARS OF AGE**

**PRENATAL HISTORY**

DURING PREGNANCY DID YOU USE:  
 DRUGS/MEDICATIONS       TOBACCO/ALCOHOL

IF YES, PLEASE LIST:

LOCATION OF BIRTH:

HOME       BIRTHING CENTER       HOSPITAL

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:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?

YES       NO

PLEASE EXPLAIN:

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES:

ULTRASOUND DURING PREGNANCY?    YES     NO    NUMBER: \_\_\_\_\_

DID YOU BREASTFEED THE BABY?       YES     NO

IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY?    YES     NO

IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

YES       NO

**LIFESTYLE HABITS**

DOES YOUR CHILD EXERCISE DAILY?    YES     NO  
 HOW MUCH?

DOES YOUR CHILD DRINK SODA?    YES     NO  
 HOW MUCH?

DOES YOUR CHILD TAKE VITAMINS?    YES     NO

DOES YOUR CHILD DO AFFIRMATIONS?  YES     NO

DOES YOUR CHILD WATCH MORE THAN AN HOUR OF TV PER DAY?  
 YES     NO    HOW MUCH?

DOES YOUR CHILD EAT BALANCED MEALS?  YES     NO

DOES YOUR CHILD EXPERIENCE PROLONGED SADNESS?  YES     NO  
 EXPLAIN:

**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.

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FREQUENT COLDS, COUGHS, ETC.
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> DIFFICULT WEIGHT GAIN	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> COLIC	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SLEEPING DIFFICULTIES

**CURRENT HEALTH STATUS**

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).

WAS THIS THE CASE FOR YOUR CHILD?                       YES     NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?

YES       NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?  YES     NO

PLEASE EXPLAIN:

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:

**COMPLETE THIS COLUMN FOR CHILDREN 5-10 YEARS**

**LIFESTYLE BEHAVIORS**

DOES YOUR CHILD EXERCISE DAILY? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD DRINK SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD HAVE DIFFICULTY SLEEPING? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:
DOES YOUR CHILD PLAY VIDEO GAMES? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD WATCH MORE THAN AN HOUR OF TV PER DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD EAT BALANCED MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD EXPERIENCE PROLONGED SADNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:

**COMPLETE THIS COLUMN FOR CHILDREN 11-18 YEARS**

**LIFESTYLE BEHAVIORS**

DOES YOUR CHILD EXERCISE DAILY? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD DRINK SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD HAVE DIFFICULTY SLEEPING? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:
DOES YOUR CHILD PLAY VIDEO GAMES? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD WATCH MORE THAN AN HOUR OF TV PER DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH?
DOES YOUR CHILD EAT BALANCED MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD EXPERIENCE PROLONGED SADNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:

**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.

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> UPSET STOMACH
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> LEARNING DISORDERS	
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> NERVOUSNESS	

**CHILD'S HEALTH HISTORY**

**INSTRUCTIONS:** Please check each of the 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.

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIFFICULTY/PAINFUL/IRREGULAR PERIODS	<input type="checkbox"/> NECK STIFFNESS/PAIN
<input type="checkbox"/> BACK PAIN/STIFFNESS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SHOULDERS/ELBOW, WRIST
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> HIPS, KNEES, ANKLES	<input type="checkbox"/> STRESS
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS

**CURRENT HEALTH STATUS**

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, CHEERLEADING, ETC.)

YES  NO

PLEASE LIST:

---

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?

YES  NO

PLEASE EXPLAIN:

---

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?  YES  NO

PLEASE EXPLAIN:

---

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:

**CURRENT HEALTH STATUS**

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, CHEERLEADING, ETC.)

YES  NO

PLEASE LIST:

---

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?

YES  NO

PLEASE EXPLAIN:

---

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?  YES  NO

PLEASE EXPLAIN:

---

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

YES  NO PLEASE EXPLAIN:

---

PLEASE RATE STRESS LEVELS ON A SCALE OF 1-10 (10 BEING HIGH)

SCHOOL: 1 2 3 4 5 6 7 8 9 10

PERSONAL: 1 2 3 4 5 6 7 8 9 10

## 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 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 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 and 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 understands 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 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.*

SIGNATURE:

DATE:

WITNESS SIGNATURE:

DATE:

## AUTHORIZATION FOR CARE OF A MINOR

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. 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 doctors in this chiropractic office and whomever they may designate as their assistant 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 Dr. 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: