Child Member Health Record

ABOUT THE CHILD

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE: | GENDER:

HEIGHT: | WEIGHT:

SIBLINGS NAMES AND AGES:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:

ADDRESS:
❑ SAME AS ABOVE

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

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):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ❑ CONDITION ❑ WELLNESS
IF CONDITION, PLEASE DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER

DID THIS CONDITION START:
❑ SUDDENLY ❑ GRADUALLY ❑ POST INJURY

WHEN DID THIS CONDITION START?

IS THIS PROBLEM: ❑ OCCASIONAL ❑ FREQUENT ❑ CONSTANT

WHAT MAKES THIS PROBLEM BETTER?

WHAT MAKES THIS PROBLEM WORSE?

SINCE THE PROBLEM BEGAN HAS IT:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ SLEEP ❑ DAILY ROUTINE ❑ EATING ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT/TESTING:

RESULTS:

As the twig is bent, so grows the tree."

COMPLETE THIS PAGE FOR CHILDREN 9-13 YEARS OF AGE

BIRTH HISTORY

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? ❑ YES ❑ NO
DID YOU SUFFER ANY TRAUMAS, FALLS, OR ACCIDENTS? ❑ YES ❑ NO
PLEASE EXPLAIN:

DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY:

❑DRUG FREE
❑ LABOR WAS CHEMICALLY INDUCED
❑ C-SECTION DELIVERY
❑ DOCTOR PULLED OR TWISTED BABY
❑SPONTANEOUS
❑ LABOR WAS DOCTOR ASSISTED
❑ FORCEPS/VACUUM EXTRACTION
❑ PREMATURE DELIVERY

PLEASE EXPLAIN:

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA?

❑BRUISNG
❑RESPIRATORY DISTRESS
❑FAST OR EXCESSIVELY LONG BIRTH
❑ODD SHAPED HEAD
❑ STUCK IN THE BIRTH CANAL
❑CORD AROUND NECK
❑LACK OF USE OF ONE ARM
❑ HEAD ROTATED TO ONE SIDE

CURRENT HEALTH HISTORY

DOES YOUR CHILD EAT WELL ❑ YES ❑ NO

ARE YOU AWARE OF THE IMPACT NUTRITION CAN HAVE ON YOUR CHILD'S BEHAVIOR? ❑ YES ❑ NO

WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION FOR YOUR CHILD?
❑ YES ❑ NO

DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS ❑ YES ❑ NO

DOES YOUR CHILD SLEEP WELL ❑ YES ❑ NO

DOES YOUR CHILD SLEEP ON HIS/HER ❑ SIDE ❑ STOMACH ❑ BACK

PLEASE DESCRIBE HIS/HER SLEEPING HABITS:

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO
DO YOU FOLLOW THE STANDARD SCHEDULE? ❑ YES ❑ NO
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT DISLOCATION?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ❑ YES ❑ NO
PLEASE EXPLAIN:

CURRENT HISTORY CONT.

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO
PLEASE EXPLAIN:

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

❑ YES ❑ NO

PLEASE LIST:

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:

DOES YOUR CHILD CARRY A BACKPACK? ❑ YES ❑ NO

WHAT IS THE APPROXIMATE WEIGHT?_____

AVE. # OF HRS OF TV/VIDEO GAMES WATCHED PER WEEK ?_____

ARE THERE ANY SMOKERS LIVING IN THE HOME? ❑ YES ❑ NO

ARE THERE ANY INDOOR PETS IN YOUR HOME? ❑ YES ❑ NO

DO YOU USE GREEN CLEANING PRODUCTS IN YOUR HOME? ❑ YES ❑ NO

PLEASE RATE YOUR CHILD'S STRESS LEVELS ON A SCALE OF 1-10 (10=HIGH)

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

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

PLEASE EXPLAIN:

LIST PRESCRIPTION MEDICATION OR SUPPLEMENTS TAKEN:

LIST ANY ALLERGIES YOUR CHILD HAS :

SYSTEMS REVIEW

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS/SYMPTOMS YOUR CHILD HAS EXPERIENCED:

- ❑ ACID REFLUX
- ❑ BED WETTING
- ❑ CONSTIPATION
- ❑ EAR INFECTIONS
- ❑ DIARRHEA
- ❑ COLIC
- ❑ ASTHMA
- ❑ POOR COORDINATION
- ❑ BRONCHITIS
- ❑ SLEEPING DIFFICULTIES
- ❑ NECK PAIN
- ❑ LOW BACK PAIN
- ❑ DIFFICULT WEIGHT GAIN
- ❑ LEARNING DISORDERS
- ❑ DIARRHEA
- ❑ FREQUENT COLDS/COUGHS/FLUS
- ❑ HYPERACTIVITY
- ❑ HEDACHES
- ❑ FEVERS
- ❑ SORE THROATS
- ❑ ALLERGIES
- ❑ URINARY PROBLEMS
- ❑ UPPER BACK PAIN
- ❑ SHORTNESS OF BREATH

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____ ❑M ❑F ❑S ❑G

DEPRESSION ❑M ❑F ❑S ❑G

DIABETES ❑M ❑F ❑S ❑G

HEART DISEASE ❑M ❑F ❑S ❑G

LIVER DISEASE ❑M ❑F ❑S ❑G

HIGH CHOLESTEROL ❑M ❑F ❑S ❑G

HIGH BLOOD PRESSURE ❑M ❑F ❑S ❑G

LUNG PROBLEMS ❑M ❑F ❑S ❑G

SEIZURES ❑M ❑F ❑S ❑G

NECK PROBLEMS ❑M ❑F ❑S ❑G

BACK PROBLEMS ❑M ❑F ❑S ❑G

SCOLIOSIS ❑M ❑F ❑S ❑G

OSTEOARTHRITIS ❑M ❑F ❑S ❑G

RHEUMATOID ARTHRITIS ❑M ❑F ❑S ❑G

AUTOIMMUNE DISEASES ❑M ❑F ❑S ❑G

OTHER:_____

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

ARE YOU AWARE THAT CHIROPRACTORS TREAT A CONDITION CALLED SUBLUXATION?
❑ YES ❑ NO

DID YOU KNOW THAT YOU CAN HAVE A SUBLUXATION WITHOUT EXPERIENCING PAIN?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ YES ❑ NO

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

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 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. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I authorize the use of this signature to allow the insurance companies to pay Triple Crown Chiropractic and Wellness directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions

Parent or Guardian Authorization Signature	Date

Triple Crown Chiropractic and Wellness

1795 Alysheba Way Suite 4103

Lexington, KY 40509