Child Member Health Record

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
PARENT EMAIL	
DATE OF BIRTH	AGE:
GENDER	
HEIGHT	WEIGHT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: ❑ SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
WORK PHONE:	
EMPLOYER NAME:	
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

VACCINATIONS/MEDICATIONS

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):

LIST PRESCRIPTION MEDICATIONS & # OF DOES CHILD HAS TAKEN:

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:

❑ WELLNESS ❑ CONDITION

IF CONDITION, DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

❑ 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/CHIROPRACTORS FOR THIS CONDITION?

❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

Access To Health

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

PRENATAL HISTORY

DURING PREGNANCY DID YOU USE:
❑ DRUGS/MEDICATIONS ❑ TOBACCO/ALCOHOL
IF YES, PLEASE EXPLAIN:

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:

HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?
_____

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?
_____

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

DID YOU EXPERIENCE ANY ILLNESS(ES) WHILE PREGNANT? ❑ YES ❑ NO
PLEASE EXPLAIN:

PLEASE DESCRIBE ANY GENETIC CONDITIONS OR DISABILITIES:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES: AT 1 MIN _____ /10 AT 5 MIN _____ /10

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

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ❑ YES ❑ NO
PLEASE EXPLAIN:

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

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 IN A CAR ACCIDENT? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ❑ 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:

DOES YOUR CHILD BANG ITS HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT? ❑ YES ❑ NO

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

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.*

❑ ACID REFLUX	❑ CONSTIPATION	❑ FREQUENT COLDS, COUGHS
❑ ASTHMA	❑ DIARRHEA	❑ HYPERACTIVITY
❑ BED WETTING	❑ DIFFICULT WEIGHT GAIN	❑ LEARNING DISORDERS
❑ COLIC	❑ EAR INFECTIONS	❑ SLEEPING DIFFICULTIES

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 was offered a copy of the Notice of Patient Privacy Policy, but **declined** it _____ Parent Initials **OR**
I have received a copy of the full Notice of Patient Privacy Policy _____Parent Initials

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:
PARENT OR GUARDIAN SIGNATURE:	DATE:

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Ranae Beard to administer chiropractic care, to work with my child's condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to my child 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 child's care for any reason, any fees for professional services rendered 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.

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 authorize the use of this signature to allow the insurance companies to pay Access to Health directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

It is our desire to post the pictures of our children patients, along with their first name and age, in our reception room to encourage parents to consider chiropractic care for their children. Please initial if you authorize this: _____

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE: