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 DOSES 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."

CHILD'S CURRENT HEALTH

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:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

HOW MANY ROUNDS OF ANTIBIOTICS HAS YOUR CHILD TAKEN? _____

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ 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 EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT? ❑ 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:

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*

❑ ASTHMA	❑ EAR INFECTIONS	❑ SORE THROAT
❑ BED WETTING	❑ HEADACHES	❑ UPSET STOMACH
❑ BRONCHITIS	❑ HYPERACTIVITY	❑ URINARY INFECTIONS
❑ CONSTIPATION	❑ LEARNING DISORDERS	❑ FREQUENT COLDS
❑ DIARRHEA	❑ NERVOUSNESS	❑ SLEEPING DIFFICULTIES

NUTRITION

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE FOOD ALLERGIES? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURING SKIN RASHES? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD ELIMINATE STOOLS EACH DAY? ❑ YES ❑ NO
PLEASE EXPLAIN:

WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?

WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?

WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?

WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?

HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?

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: