APPLICATION FOR CARE

Child Health Record

HR # _____

PATIENT DEMOGRAPHICS

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH: | AGE:

GENDER: ❑ MALE ❑ FEMALE | SOCIAL SECURITY NUMBER:

BIRTH HEIGHT: | BIRTH WEIGHT:

RACE: ❑ AMERICAN INDIAN or ALASKA NATIVE ❑ ASIAN ❑ BLACK or AFRICAN AMERICAN ❑ WHITE (CAUCASIAN) ❑ OTHER ❑ I DECLINE TO ANSWER

ETHNICITY: ❑ HISPANIC or LATINO ❑ NOT HISPANIC OR LATINO ❑ I DECLINE TO ANSWER

MOTHER'S NAME:

MOTHER'S DATE OF BIRTH: | MOTHER'S CELL PHONE:

FATHER'S NAME:

FATHER'S DATE OF BIRTH: | FATHER'S CELL PHONE:

WHO IS RESPONSIBLE FOR PAYMENT:

RESPONSIBLE PAYOR'S SOCIAL SECURITY NUMBER:

DO YOU HAVE HEALTH INSURANCE: ❑ YES ❑ NO

SUPPLEMENTS AND MEDICATIONS

LIST PRESCRIPTION AND NON-PRESCRIPTION DRUGS YOUR CHILD TAKES:

DOES YOUR CHILD HAVE ANY MEDICATION ALLERGIES? ❑ NO ❑ YES
IF YES WHAT MEDICATION AND REACTION:

LIST VITAMINS AND SUPPLEMENTS YOUR CHILD TAKES:

Date: _____

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HOW HAVE YOU SEEN OR HEARD OF OUR OFFICE (√ ALL THAT APPLY)
❑ NEWSPAPER ❑ SIGN ❑ INTERNET ❑ COMMUNITY EVENT ❑ MAILING

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

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HISTORY OF COMPLAINT

PURPOSE OF THIS VISIT:
❑ WELLNESS CHECK-UP ❑ INJURY or ACCIDENT ❑ OTHER

PLEASE EXPLAIN:

IS YOUR CHILD EXPERIENCING PAIN/DISCOMFORT? IF YES WHERE/HOW LONG:

WHEN DID PROBLEM FIRST BEGIN:
DATE ____/____/____ ❑ UNKNOWN
❑ GRADUAL ❑ SUDDEN

EVER HAD THIS PROBLEM BEFORE:
❑ NO ❑ YES
IF YES, WHEN? _____

ANY BOWEL OR BLADDER PROBLEMS SINCE THIS PROBLEM BEGAN:
❑ NO ❑ YES
IF YES, DESCRIBE:

HAS YOUR CHILD SEEN ANY OTHER DOCTORS FOR THIS PROBLEM:
❑ NO ❑ YES
IF YES, WHO: _____
HOW LONG AGO: _____DAYS _____WEEKS _____MONTHS _____YEARS

WHAT WERE THE RESULTS OF PAST TREATMENT:

HOW IS THIS PROBLEM NOW: ❑ ON & OFF ❑ RAPIDLY IMPROVING ❑ IMPROVING SLOWLY ❑ ABOUT THE SAME ❑ GRADUALLY WORSENING

PLEASE LIST ANY MEDICATION TAKEN FOR THIS PROBLEM:

HAS YOUR CHILD EVER BEEN INJURED PLAYING ORGANIZED SPORTS:
❑ NO ❑ YES
IF YES, PLEASE EXPLAIN:_____
_____

HAS YOUR CHILD EVER BEEN INJURED IN AN AUTO ACCIDENT:
❑ NO ❑ YES
IF YES, PLEASE EXPLAIN:_____
_____

HEALTHY CHOICE
FAMILY CHIROPRACTIC

Name: _____ HR #_____ Date: _____

HEALTHY CHOICE
FAMILY CHIROPRACTIC

PAST HISTORY

HAS YOUR CHILD EVER SUFFERED FROM: *CHECK ALL THAT APPLY*

❑ HEADACHES	❑ DIZZINESS	❑ NECK PROBLEMS
❑ POOR APPETITE	❑ ADD/ADHD	❑ FAINTING
❑ ARM PROBLEMS	❑ STOMACH ACHES	❑ RUPTURES/HERNIA
❑ LEG PROBLEMS	❑ REFLUX	❑ MUSCLE PAIN
❑ JOINT PROBLEMS	❑ HEART TROUBLE	❑ CONSTIPATION
❑ GROWING PAINS	❑ CHRONIC EARACHES	❑ BACKACHES
❑ DIARRHEA	❑ ASTHMA	❑ SINUS TROUBLE
❑ POOR POSTURE	❑ HYPERTENSION	❑ WALKING TROUBLE
❑ SCOLIOSIS	❑ ANEMIA	❑ COLDS/FLU
❑ SLEEPING PROBLEMS	❑ BED WETTING	❑ COLIC
❑ BROKEN BONES	❑ DIGESTIVE DISORDERS	❑ BEHAVIORAL PROBLEMS
❑ ORTHOPEDIC PROBLEMS	❑ SEIZURES/ CONVULSIONS	❑ FALL OFF SWING
❑ FALL IN BABY WALKER	❑ FALL FROM BED OR COUCH	❑ FALL FROM CRIB
❑ FALL DOWN STAIRS	❑ FALL OFF BICYCLE	❑ FALL FROM HIGH CHAIR
❑ FALL OFF SKATEBOARD/ SKATES	❑ FALL FROM CHANGING TABLE	❑ FALL OFF MONKEY BARS
❑ FALL OFF SLIDE	❑ OTHER _____	
❑ ALLERGIES TO _____		

FAMILY HISTORY

DOES ANYONE IN YOUR FAMIY SUFFER WITH THE SAME CONDITION(S)?
❑ NO ❑ YES **IF YES WHOM:** ❑ GRANDMOTHER ❑ GRANDFATHER ❑ MOTHER ❑ FATHER ❑ SISTER(S) ❑ BROTHER(S) ❑ SON(S) ❑ DAUGHTER(S)

HAVE THEY EVER BEEN TREATED FOR THEIR CONDITION?
❑ NO ❑ YES ❑ I DON'T KNOW

ANY OTHER HEREDITARY CONDITIONS THE DOCTOR SHOULD BE AWARE OF? ❑ NO ❑ YES:

IF YES, DESCRIBE:

For office use only

Height:_____ Weight:_____

Blood Pressure:_____/_____

INFORMED CONSENT

I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO HEALTHY CHOICE FAMILY CHIROPRACTIC FOR ALL FEES ASSOCIATED WITH CHIROPRACTIC CARE MY CHILD RECEIVES.

THE RISKS ASSOCIATED WITH EXPOSURE TO IONIZATION AND SPINAL ADJUSTMENTS HAVE BEEN EXPLAINED TO ME TO MY COMPLETE SATISFACTION, AND I HAVE CONVEYED MY UNDERSTANDING OF THESE RISKS TO THE DOCTOR. AFTER CAREFUL CONSIDERATION I DO HEREBY REQUEST AND AUTHORIZE IMAGING STUDIES AND CHIROPRACTIC ADJUSTMENTS FOR THE BENEFIT OF MY MINOR CHILD FOR WHOM I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES ON BEHALF OF.

❑ UNDER THE TERMS AND CONDITIONS OF MY DIVORCE, SEPARATION OR OTHER LEGAL AUTHORIZATION, THE CONSENT OF A SPOUSE/FORMER SPOUSE OR OTHER GUARDIAN IS NOT REQUIRED. IF MY AUTHORITY TO SO SELECT AND AUTHORIZE THIS CARE SHOULD CHANGE IN ANY WAY, I WILL IMMEDIATELY NOTIFY THIS OFFICE.

_____ _____/_____/_____ _____ _____/_____/_____

PARENT OR LEGAL GUARDIAN'S SIGNATURE **DATE** **DOCTOR'S SIGNATURE** **DATE**

MEDICAL INFORMATION RELEASE FORM (HIPAA)

NAME:_____ **DATE OF BIRTH:**_____/_____/_____

RELEASE OF INFORMATION:

❑ I authorize the release of information including the diagnosis, records; examination rendered to my child and claims information. This information may be released to:

❑ Name_____Relationship_____

❑ Information is not to be released to anyone

This ***Release of Information*** will remain in effect until terminated by me in writing.

_____ _____/_____/_____ ☐ *Witness Initials*

PARENT OR LEGAL GUARDAN'S SIGNATURE *Date*