ADVANCED CHIROPRACTIC

# CHILD'S HEALTH RECORD

## ABOUT THE CHILD

| | | |
|---|---|---|
| CHILD'S NAME: | | |
| ADDRESS: | | |
| CITY: | | STATE/ZIP CODE: |
| DATE OF BIRTH: | | AGE: |
| GENDER: | HEIGHT: | WEIGHT: |

## ABOUT THE PARENT'S

| | |
|---|---|
| PARENT'S NAMES: | |
| ADDRESS:<br>❑ SAME AS ABOVE | |
| CITY: | STATE/ZIP CODE: |
| HOME PHONE: | CELL PHONE: |
| EMAIL ADDRESS: | |
| EMPLOYER: | |

## CHILD'S HEALTH HISTORY

**INSTRUCTIONS:** *Please check each of the diseases or conditions that the child now has 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.*

| | | |
|---|---|---|
| ❑ ALLERGIES | ❑ CONSTIPATION | ❑ IRRITABILITY |
| ❑ ASTHMA | ❑ DIGESTIVE PROBLEMS | ❑ SKIN PROBLEMS |
| ❑ ATTENTION PROBLEMS | ❑ EAR INFECTIONS | ❑ SLEEPING DISORDERS |
| ❑ BED WETTING | ❑ FREQUENT COLDS | ❑ TUBES IN THE EARS |
| ❑ BREATHING PROBLEMS | ❑ HEADACHES | ❑ VISION PROBLEMS |
| ❑ COLIC | ❑ HYPERACTIVITY | ❑ GROWING PAINS |
| ❑ OTHER:_____ | ❑ OTHER:_____ | ❑ OTHER:_____ |

## VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO

HOW MANY VACCINATIONS HAS YOUR CHILD HAD?

❑ ALL ❑ MOST ❑ SOME EXPLAIN:

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

❑ FEVER ❑ LETHARGY ❑ FUSSINESS ❑ SEIZURES

## CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR WELLNESS CENTER BECAUSE OF (CHECK ALL THAT APPLY):

❑ FRIENDS & FAMILY ❑ CO-WORKERS ❑ INTERNET ❑ MAILING
❑ SIGN ❑ COMMUNITY EVENT ❑ NEWSPAPER

HAS YOUR CHILD 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:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

❑ WELL CHECK ❑ FALL ❑ HOME INJURY ❑ SPORTS ❑ AUTO

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
❑ SCHOOL ❑ PLAY ❑ BEHAVIOR

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?

❑ YES ❑ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?

❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

## MOTHER'S PREGNANCY & LABOR

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

WAS THE BABY EVER IN THE BREECH POSITION? ❑ YES ❑ NO

DID YOU HAVE AN ULTRASOUND DURING PREGANCY? ❑ YES ❑ NO
HOW MANY?_____

DESCRIBE YOUR DELIVERY:

❑ LABOR WAS CHEMICALLY INDUCED ❑ EPIDURAL
❑ C-SECTION DELIVERY ❑ FORCEPTS/VACUUM EXTRACTION
❑ DOCTOR PULLED OR TWISTED BABY ❑ PREMATURE DELIVERY
❑ HOME BITH ❑ WATER BIRTH ❑ DULA/MIDWIFE ASSISTED
PLEASE EXPLAIN:

HOW LONG WAS THE LABOR? _____
HOW LONG WAS THE DELIVERY? _____

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

DID YOU BREASTFEED? ❑ YES HOW LONG?_____ ❑ NO

DID YOU EXPERIENCE FEEDING PROBLEMS? ❑ YES ❑ NO

DID YOUR BABY HAVE COLIC? ❑ YES ❑ NO

VACCINATIONS DURING PREGNANCY? (EX. FLU SHOT) ❑ YES ❑ NO

## ARE YOU AWARE THAT

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
❑ YES ❑ NO

IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE?
❑ YES ❑ NO

## CHILD'S CURRENT HEALTH

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

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

HAS YOUR CHILD EVER FALLEN FROM A HEIGHT OVER 3 FEET?
❑ YES ❑ NO
PLEASE EXPLAIN:

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

IS YOUR CHILD ACCIDENT PRONE? ❑ YES ❑ NO
PLEASE EXPLAIN:

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

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ❑ 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:

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

**Consent to evaluate and adjust a minor child**

I, _____ being the parent or legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care. In addition, the statements made on this form are accurate to the best of my recollection.

_____ _____
Signature Date

**Advanced Chiropractic, P.A.**
2485 Maplewood Drive Suite 215 Maplewood, MN 55109
651-770-7938 www.advancedchiromn.com

## Terms of Acceptance

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 main practice objective is to eliminate and correct the presence of vertebral subluxations and their interference to the body using specific adjustments.

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.

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.

## Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below whom I am legally responsible) by the licensed doctors of chiropractic of Advanced Chiropractic, P.A. or any doctor, who now or in the future, works as a relief doctor.

I authorize payment of insurance benefits directly to Advanced Chiropractic, P.A. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Advanced Chiropractic, P.A. to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I understand that if any payments from my insurance company are sent to me for services rendered at Advanced Chiropractic, P.A, that I am responsible for getting said payments applied to my account and any outstanding charge. I realize that my insurance benefits are a contract/agreement between myself and my insurance company, and Advanced Chiropractic, P.A. is not responsible for quoting medical benefits. Any benefits quoted are just an estimation. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ _____

Signature Date

## 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 fully understand the Terms of Acceptance and Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have also read and understand the Notice of Privacy Practices and that 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. I therefore accept chiropractic care on this basis.*

_____ _____

Patient Name *(Please Print)* Relationship to Patient *(If Patient is a Minor)*

_____ _____

Signature Date

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