

Child Member Health Record

9 years to 13 years old

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: <input type="checkbox"/> 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): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> CONDITION <input type="checkbox"/> WELLNESS IF CONDITION, PLEASE DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER
DID THIS CONDITION START: <input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> POST INJURY
WHEN DID THIS CONDITION START?
IS THIS PROBLEM: <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> FREQUENT <input type="checkbox"/> CONSTANT WHAT MAKES THIS PROBLEM BETTER?
WHAT MAKES THIS PROBLEM WORSE?
SINCE THE PROBLEM BEGAN HAS IT: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> EATING <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME AND SPECIALTY:
TYPE OF TREATMENT/TESTING:
RESULTS:

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:

- | | |
|--|--|
| <input type="checkbox"/> DRUG FREE | <input type="checkbox"/> SPONTANEOUS |
| <input type="checkbox"/> LABOR WAS CHEMICALLY INDUCED | <input type="checkbox"/> LABOR WAS DOCTOR ASSISTED |
| <input type="checkbox"/> C-SECTION DELIVERY | <input type="checkbox"/> FORCEPS/VACUUM EXTRACTION |
| <input type="checkbox"/> DOCTOR PULLED OR TWISTED BABY | <input type="checkbox"/> PREMATURE DELIVERY |

PLEASE EXPLAIN:

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

- | | |
|---|---|
| <input type="checkbox"/> BRUISING | <input type="checkbox"/> STUCK IN THE BIRTH CANAL |
| <input type="checkbox"/> RESPIRATORY DISTRESS | <input type="checkbox"/> CORD AROUND NECK |
| <input type="checkbox"/> FAST OR EXCESSIVELY LONG BIRTH | <input type="checkbox"/> LACK OF USE OF ONE ARM |
| <input type="checkbox"/> ODD SHAPED HEAD | <input type="checkbox"/> HEAD ROTATED TO ONE SIDE |

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 :

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:

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:

- | | |
|--|---|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> DIFFICULT WEIGHT GAIN |
| <input type="checkbox"/> BED WETTING | <input type="checkbox"/> LEARNING DISORDERS |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> FREQUENT COLDS/COUGHS/FLUS |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> HYPERACTIVITY |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FEVERS |
| <input type="checkbox"/> POOR COORDINATION | <input type="checkbox"/> SORE THROATS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> ALLERGIES |
| <input type="checkbox"/> SLEEPING DIFFICULTIES | <input type="checkbox"/> URINARY PROBLEMS |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> UPPER BACK PAIN |
| <input type="checkbox"/> LOW BACK PAIN | <input type="checkbox"/> 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 _____
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | DEPRESSION
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | DIABETES
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| HEART DISEASE
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | LIVER DISEASE
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | HIGH CHOLESTEROL
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| HIGH BLOOD PRESSURE
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | LUNG PROBLEMS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | SEIZURES
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| NECK PROBLEMS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | BACK PROBLEMS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | SCOLIOSIS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| OSTEOARTHRITIS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | RHEUMATOID ARTHRITIS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | |
| AUTOIMMUNE DISEASES
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | | |

OTHER: _____

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT NOT ALL CHIROPRACTIC CARE IS THE SAME AND NOT EVERY CHIROPRACTIC APPROACH IS SPECIFIC?
 YES NO

ARE YOU AWARE THAT 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 SYMPTOMS OFTEN TIMES ARE THE LAST TO SHOW UP?
 YES NO

DID YOU KNOW THAT YOU CAN HAVE LOSS OF FUNCTION 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

DID YOU KNOW THAT CHIROPRACTIC CARE CAN HELP CHILDREN FUNCTION OPTIMALLY TOO?
 YES NO

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1. _____
2. _____
3. _____

IF YOU HAVE ANY OTHER CONCERNS NOT PREVIOUSLY LISTED ON THESE FORMS, PLEASE WRITE THEM IN USING THE SPACE BELOW.

THANK YOU FOR CHOOSING VERITY HEALTH CENTER AND HELPING US TO CONTINUE ON OUR MISSION TO
HELP FAMILIES EXPERIENCE TRUE HEALTH!

"It is easier to build strong children than repair broken men."

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.

To receive text appointment reminders, initial here _____

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

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests. Symptoms may change over the course of chiropractic care. Following the recommended schedule will ensure the best results.

Name: _____

Date: _____

Witness: _____

Date: _____

Doctor's Signature: _____

Date: _____