

Child Member Health Record

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

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:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH:	

VACCINATIONS/MEDICATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
LIST PRESCRIPTION MEDICATION & # 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): <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"/> WELLNESS <input type="checkbox"/> CONDITION
IF CONDITION, 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 PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <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"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

COMPLETE THIS PAGE FOR CHILDREN 4-8 YEARS OF AGE

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:

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? YES NO
 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

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> UPSET STOMACH
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> LEARNING DISORDERS	
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> NERVOUSNESS	

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 OCCURRING 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?

"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.

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

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 hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me 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 care for any reason, any fees for professional services rendered me 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.

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

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:

DATE:

Family First Chiropractic
11901 Hwy 65
Blaine, MN 55434

NOTICE OF CANCELLATION POLICY

CANCELLATION POLICY – EFFECTIVE NOVEMBER 01, 2019

It is the policy of Family First Chiropractic Center to assess a \$25 missed visit fee to patients who cancel appointments with less than a 5 hour notice. One missed visit will not result in the assessment for a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and families, and missed visits result in time lost that could have been used to provide care for others. My signature below indicates that I understand the above missed visit policy

SIGNATURE: _____ **DATE:** _____

PAYMENT AUTHORIZATION – EFFECTIVE NOVEMBER 01, 2019

My signature below states that I authorize Family First Chiropractic Center to process my cancellation fee within 30 days of the missed appointment. I agree to provide a credit/debit card to keep on my secure account for any future payments.

SIGNATURE: _____ **DATE:** _____