CHILD MEMBER HEALTH RECORD

ABOUT THE CHILD

Name: _____

Address: _____

City/State/Zip: _____

Home phone: _____

Date of Birth: _____ Gender: _____

Height:_____ Weight: _____

ABOUT THE PARENTS

Father's Name: _____

Mother's Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____

Job Title/Type of work: _____

Work Phone: _____

Insurance Company: _____

Primary Holder's Name: _____

Primary Holder's Date of Birth: _____

VACCINATIONS

Have you chosen to vaccinate your child?

❑ YES ❑ NO

If yes, please check all vaccinations your child has received:

❑DPT ❑MMR ❑Chicken Pox

❑Hepatitis ❑Other : _____

_____

Please describe any and all reactions to vaccines:_____

_____

CHIROPRACTIC EXPERIENCE

Who referred you to our office?_____

Have you seen or heard of our office through (check all that apply):

❑Community Event ❑Newspaper ❑Mailing

❑Yellow Pages ❑Sign

Have you been adjusted by a Chiropractor before? **Y / N**

What was the reason for the visit? _____

Doctor's Name: _____

Approximate date of last visit: _____

Has any adult in your family ever seen a Chiropractor? **Y / N**

Has any child in your family ever seen a Chiropractor? **Y / N**

REASON FOR THIS VISIT

Describe the reason for this visit: _____

_____

_____

Is the purpose of this appointment related to:

❑Sports ❑Auto Accident ❑Fall

❑Home Injury ❑Chronic Discomfort ❑Other

Briefly Explain: _____

_____

When did this condition begin? Date:_____

Has this condition:

❑Gotten worse ❑Stayed the same ❑Come and gone

Does this condition interfere with:

❑Sleep ❑Daily Routine ❑Other Activities

Briefly Explain: _____

_____

Has this condition occurred before?

❑ YES ❑ NO

Briefly Explain: _____

_____

Have you seen other Doctors for this condition?

❑ YES ❑ NO

Type of treatment? _____

Results: _____

Discover Health Chiropractic, PC
1136 W. Divide Ave.
Bismarck, ND 58501

MOTHER'S PREGNANCY & LABOR

During pregnancy did you use:
❑Drugs/medications ❑Tobacco/alcohol
If yes, please explain: _____

Describe your delivery:
❑Labor was chemically induced ❑Doctor assisted in labor
❑Forceps/vacuum were used ❑Delivered by c-section
❑Doctor pulled or twisted baby ❑Premature delivery
Please explain: _____

Did you nurse the baby? ❑ YES ❑ NO
Did you experience feeding problems? ❑ YES ❑ NO
Did your baby have colic? ❑ YES ❑ NO

CHILD'S HEALTH HISTORY

Please check each of the conditions or diseases that the child 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 or possibility of being accepted for care:

❑ Digestive Problems	❑ Attention Problems	❑ Breathing Problems
❑ Allergies	❑ Constipation	❑ Irritability
❑ Asthma	❑ Ear Problems	❑ Tubes in ears
❑ Bed wetting	❑ Frequent Colds	❑ Vision Problems
❑ Skin Problems	❑ Headaches	❑ Sleep Disorders
❑ Hyperactivity	❑ Other:	

CHILD'S CURRENT HEALTH STATUS

Has your child ever taken Antibiotics?
❑ YES ❑ NO

Has your child ever been hospitalized?
❑ YES ❑ NO

Has your child ever had a severe fall?
❑ YES ❑ NO

Has your child ever been in a car accident?
❑ YES ❑ NO

Is your child accident prone?
❑ YES ❑ NO

Has your child ever had surgery?
❑ YES ❑ NO

Is your child currently taking any medications?
❑ YES ❑ NO
Please list: _____
_____
_____

Does your child have difficulty interacting with other children?
❑ YES ❑ NO

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?
❑ YES ❑ NO

What changes (if any) in your child's health or behavior would you like accomplished? _____
_____

CHIROPRACTIC AWARENESS

Doctors of Chiropractic work with the nervous system?
❑ YES ❑ NO

Chiropractic is the world's largest natural healing profession in the world?
❑ YES ❑ NO

The nervous system controls all bodily functions and systems?
❑ YES ❑ NO

If Chiropractic care begins at birth, you can help your children achieve a higher level of health throughout life? ❑ YES ❑ NO

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 to 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 Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that 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 Discover Health Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

_____ _____ _____
Parent or Guardian Signature | Relationship to patient | Date