Child Member Health Record

Child Member Health Record (page 1 of 4)
Most of this editable PDF can be filled out on your computer. Please fill out, print, sign & date, and bring to your appointment.

Aligned for Life Chiropractic
91 Newport Pike, Suite 305
Gap, PA 17527
(717) 435-3935

ABOUT THE CHILD

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

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: ❑ SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER:	
INSURANCE COMPANY:	

VACCINATIONS/MEDICATIONS

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

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:
❑ DPT ❑ MMR ❑ CHICKEN POX ❑ HEPATITIS ❑ OTHER _____

DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S):

LIST PRESCRIPTION MEDICATIONS & # OF DOSES YOUR CHILD HAS TAKEN:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (CHECK ALL THAT APPLY):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU 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:

REASON FOR THIS VISIT

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER
PLEASE EXPLAIN:

WHEN DID THIS CONCERN BEGIN?

HAS THIS CONCERN:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONCERN INTERFERE WITH:
❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONCERN OCCURRED BEFORE? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

CHILD'S CURRENT HEALTH

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

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 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?
PLEASE EXPLAIN: ❑YES ❑NO

DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT?
PLEASE EXPLAIN: ❑YES ❑NO

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS?
(I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)
PLEASE LIST: ❑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:

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

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

CHILD'S HEALTH HISTORY

INSTRUCTIONS: Please check each of the 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 care plan and the possibility of being accepted for care.

❑ ANXIETY	❑ DEPRESSION	❑ LEARNING DISORDERS
❑ ASTHMA	❑ DIFFICULTY/PAINFUL/ IRREGULAR PERIODS	❑ NECK STIFFNESS/PAIN
❑ BACK PAIN/STIFFNESS	❑ HEADACHES	❑ SHOULDERS/ELBOW/ WRIST PAIN
❑ CONSTIPATION	❑ HIPS, KNEES, ANKLES	❑ STRESS
❑ DIARRHEA	❑ HYPERACTIVITY	❑ URINARY INFECTIONS
❑ ACID REFLUX	❑ DIFFICULT WEIGHT GAIN	❑ FREQUENT COLDS/COUGHS
❑ COLIC	❑ EAR INFECTIONS	❑ SLEEPING DIFFICULTIES
❑ BED WETTING	❑	❑

NUTRITION

DO YOU HAVE ANY CONERNS 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 OCCURING SKIN RASHES?
PLEASE EXPLAIN: ❑YES ❑NO

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?

STATEMENT OF FINANCIAL UNDERSTANDING

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she 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 that if I suspend or terminate my care, 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 understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Patients with chiropractic insurance will be expected to pay any deductible or coinsurance amount they owe on the date of service. I understand that if there is a problem with my insurance I will pay ***Aligned for Life Chiropractic*** for any outstanding charges. ***Aligned for Life Chiropractic*** has no control over the payment of your claim by your insurance company. If you do not carry insurance we ask that **all charges be paid at the time of service.**

Auto accident and workers compensation claims will be billed entirely to the insurance company. However, it is your responsibility to obtain the proper forms and notify your employer and/or insurance company of the injury/accident. If the claim should be denied or rejected I understand that I'm responsible for the payment of all charges.

Sign if Read Above _____ Date _____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their own PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained for one time for all the subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your own security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures and our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with a privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient of authorize signature _____ Date _____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulations is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend his consent to apply to all my present and future care with Dr. Sekora Wallace-Henderson.

Dated this _____ day of 20_____.

_____ _____

Patient Signature (or Legal Guardian) Signature of Witness

_____ _____

Print Name: Print Name: