Premier Family Healthcare LLC
Chiropractic Lifestyle Center

Child Member Health Record

ABOUT THE CHILD

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE:

GENDER: | WEIGHT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME

ADDRESS:
☐ SAME AS ABOVE

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

WORK PHONE: | POSITION TITLE:

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 CHILD:

CHIROPRACTIC

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):
☐ NEWSPAPER ☐ SIGN ☐ WEBSITE ☐ COMMUNITY
☐ EVENT ☐ MAILING ☐ OTHER

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
☐ YES ☐ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTORS NAME:

APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
☐ WELLNESS ☐ CONDITION

IF CONDITION, DESCRIBE:

IS THE PURPOSE OF THIS VISIT RELATED TO:
☐ SPORTS ☐ AUTO ☐ FALL ☐ HOME INJURY ☐ OTHER

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

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?
☐ YES ☐ NO

DOCTORS NAME:

TYPE OF TREATMENT:

RESULTS:

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"As the twig is bent, so grows the tree."

COMPLETE THIS PAGE FOR CHILDREN 0-3 YEARS OF AGE

PRENATAL HISTORY

DURING PREGNANCY DID YOU USE:
☐ DRUGS/MEDICATIONS ☐ TOBACCO/ALCOHOL

IF YES, PLEASE EXPLAIN:

LOCATION OF BIRTH:
☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL

DESCRIBE YOUR DELIVERY:

☐ LABOR WAS CHEMICALLY INDUCED ☐ LABOR WAS DOCTOR ASSITED
☐ C-SECTION DELIVERY ☐ FORCEPS/VACUUM DELIVERY
☐ DOCTOR PULLED OR TWISTED BABY ☐ PREMATURE DELIVERY

PLEASE EXPLAIN:

HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTION TO THE BIRTH?

_____

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?

_____

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

DID YOU EXPERIENCE ANY ILLNESSES WHILE PREGNANT?
☐ YES ☐ NO
PLEASE EXPLAIN:

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES FOR MOTHER OR CHILD:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES: AT 1 MIN._____ AT 5 MIN_____/10

ULTRASOUND DURING PREGNANCY? ☐ YES ☐ NO NUMBER____

DID YOU BREASTFEED THE BABY? ☐ YES ☐ NO
IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY? ☐ YES ☐ NO
IF YES, FOR HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COWS MILK:

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE:
☐ YES ☐ NO

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 accepted.*

☐ ACID REFLUX	☐ CONSTIPATION	☐ FREQUENT COLDS, COUGHS
☐ ASTHMA	☐ DIARRHEA	☐ HYPERACTIVITY
☐ BED WETTING	☐ DIFFICULT WEIGHT GAIN	☐ LEARNING DISORDERS
☐ COLIC	☐ EAR INFECTIONS	☐ SLEEPING DIFFICULTIES

NUTRITION

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

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

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE. (I.E: BED, CHANGING TABLE, STAIRS, ETC.)
WAS THIS THE CASE FOR YOUR CHILD? ☐ 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 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?

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

AUTHORIZATION TO RELEASE INFORMATION

In the event that you are not available to receive personal information, such as lab results, billing information, and/or medical information your consent is required in order for another person to obtain this information.

I authorize Premier Family Healthcare and/or their staff to leave medical information to the following people: Please list names of authorized people and what type of information we may release to them:

Name: _____ Relation:_____

Medical _____ Billing_____ Appointments_____ All_____ Other_____

Name: _____ Relation: _____

Medical _____ Billing_____ Appointments_____ All_____ Other_____

I authorize Premier Family Healthcare and/or their staff to release any information required in the course of my examinations or treatments.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____

I **do not** authorize any information to be released to anyone other than myself.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you were offered a copy of the Notice of Privacy Practices for Premier Family Healthcare, LLC, (H.I.P.P.A.) located at the front desk.

The Notice explains how your medical information can be used and disclosed and how you can access that information. We encourage you to read it. If you have any questions, call the contact person on the front of the Notice.

I acknowledge that I was offered the Notice of Privacy Practices of Premier Family Healthcare, LLC, and the other health care providers that are part of its system, including those listed on the front of the Notice.

Print Name: _____ Date: _____

Signature: _____

Relationship to Patient (if under 18): _____

AUTHORIZATION FOR CARE

I hear by authorize the doctors in this chiropractic office and whoever 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.

Print Name: _____Date: _____

Signature: _____

Relationship to Patient (if under 18): _____