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 9-13 YEARS OF AGE

CURRENT HEALTH STATUS

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 NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?
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 TYPE SPORTS (I.E: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.) ☐ YES ☐ NO
PLEASE LIST:

PLEASE RATE YOUR CHILDS 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?

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.*

☐ ANXIETY	☐ DEPRESSION	☐ LEARNING DISORDERS
☐ ASTHMA	☐ NECK STIFFNESS/PAIN	☐ HEADACHES
☐ CONSTIPATION	☐ HIPS,KNEES, ANKLES	☐ STRESS
☐ DIARRHEA	☐ HYPERACTIVITY	☐ BACK PAIN/STIFFNESS
☐ URINARY INFECTIONS	☐ DIFFICULTY/PAINFUL/IRREGULAR PERIODS	

NUTRITION

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILDS 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? ☐ 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?

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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): _____