CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name_____

Phone_____ Birthdate_____

Age_____ Gender ___Male ___Female

Height_____ Weight_____

Address _____

City/State/Zip _____

Parent's Name _____

Parent's Employer _____

Parent's Work Phone _____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:

….. take any medication? No / Yes

Explain_____

….. smoke or consume alcohol? No / Yes

….. experience any illness? No / Yes

Explain_____

Approximately how long did labor last? _____ hours

Was labor chemically induced? No / Yes

Was labor doctor assisted? No / Yes

Was a C-Section performed? No / Yes

Were forceps or vacuum extraction used? No / Yes

Did the delivery doctor pull or twist the baby during delivery? No / Yes

Was the delivery premature? No / Yes

If "Yes", at _____ month & _____ weight

Check any of the following if the child experienced it immediately after birth.

___ Jaundice ___ Respiratory Problems
___ Feeding Problems ___Displaced or Broken Joints
___ Other Condition(s)

Explain _____

REASON FOR THIS VISIT

Describe the purpose of this visit. _____

Is the purpose of this appointment related to:
___Sports ___Auto Accident ___ Fall ___ Injury
___Chronic Discomfort ___Other
Explain _____

When did this condition begin_____

Has this condition: ___Gotten Worse __Stayed Constant
___Comes & Goes

Does this condition interfere with:

___Sleep ___Daily Routine ___Other Activities

Explain_____

Has this condition occurred before? ___Yes ___No

Explain_____

Have you seen other doctors for this? ___Yes ___No

Dr.'s Name(s)_____

Type of Treatment_____

Results_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis.

___ Vision Problems
___ Headaches
___ Sleeping Disorders
___ Irritability
___ Skin Problems
___ Allergies
___ Breathing Problems
___ Asthma
___ Hyperactivity
___ Constipation
___ Bed Wetting
___ Pink Eye
___ Ear Problems
___ Tubes in the ears
___ Attention Problems
___ Frequent Colds
___ Colic
___ Digestive Problems
___ Other _____
_____
_____
_____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? ___ No ___ Yes
Has your child:
…..been hospitalized? ___ No ___ Yes
…..had a severe fall? ___ No ___ Yes
…..been in a car accident? ___ No ___ Yes

Has your child ever taken antibiotics? ___ No ___ Yes
If "Yes", Explain _____

Is he/she currently taking any medication? __ No __ Yes
If "Yes", Explain _____

Does your child have difficulty interacting with schoolmates or friends? ___ No ___ Yes

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?
___ No ___ Yes

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

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

___ **Relief Care** Symptomatic relief of pain or discomfort

___ **Corrective Care** Correcting and relieving the cause of the problem as well as the symptoms.

___ **Comprehensive Care** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

___ I want the Doctor to select the type of care appropriate for my child.

_____
Parent/Guardian's Signature Date

VACCINATIONS

Have you chosen to vaccinate your child? ___ No ___ Yes If "Yes", check all vaccinations the child has received.

___ DPT ___ MMR ___ Polio ___ Chicken Pox ___ Hepatitis ___ Other_____

Describe any and all reactions to vaccine(s)._____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors in the Chiropractic office, and whomever they may designate as their assistants to administer Chiropractic care, to work with my child (name) _____ through the use of adjustments and procedures to the spine, as the Doctor deems appropriate.

I clearly understand and agree that all services rendered 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 my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. 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. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

_____ _____
Patient's Name (PRINT) Parent or Legal Guardian's Name (PRINT)

_____ _____ _____
Parent/Guardian's Signature DATE Witness' Signature

Loving Chiropractic of Stuart, Inc
632 SE Monterey Road, Stuart, FL 34994
772-219-3313

Terms of Acceptance / Informed Consent / Assignment of Benefits

Dear Client:

When a person seeks chiropractic health care and we accept a client for such care, it is essential for both to be working towards the same objective. It is important that the client understands both the objective and the method that will be used to attain this goal. Understanding this will prevent any confusion or disappointment.

Health: A state of optimal physical, emotional and spiritual well being, not merely the absence of symptoms, disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column that causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is specific restorative adjustments, plus traction and postural activities to help maintain those adjustments. Chiropractic adjustments are the moving of bones with the doctor's hand or with the use of a machine.

At Loving Chiropractic of Stuart, Inc our personnel are specifically trained to assist the doctor with portions of your consultation, examination, x-ray taking, traction, postural activities, massage therapy, etc.

At Loving Chiropractic of Stuart, Inc. our ONLY PRACTICE OBJECTIVE is to assist your body to function at its maximal health potential by eliminating the major interference to your body's innate expression. We do not offer advice regarding care prescribed by others or diagnose or care for any disease or condition other than your body's subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or care for those findings, we will recommend that you seek the services of another health care provider.

Patient Name: _____ I have read and fully understand the above statements and I therefore accept chiropractic care for myself or this minor child on this basis.

I hereby assign Loving Chiropractic of Stuart, Inc. insurance benefits and any causes of action on all insurance policies otherwise payable to me. I am financially responsible for any deductible, co-payment, co-insurance or non-covered services. I further authorize Loving Chiropractic of Stuart, Inc. to release information necessary to apply for payment for these benefits.

Patient, Parent or Guardian Signature: _____ **Date**: _____

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Loving Chiropractic of Stuart, Inc.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Loving Chiropractic of Stuart, Inc.. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative **Printed Name of Patient**

_____ _____

Date of Signing **Description of Personal Representative's Authority**