Curley Chiropractic

Child's Health History Form

Personal Data

Today's Date _____

Name_____ Age_____ Date of Birth_____

Parent's names_____

Home Address_____City_____State_____Zip_____

Home Phone (___)_____Ema-address_____

Cell Phone (___)_____ Cell Provider_____

SS#(opt'l)_____Emergency contact_____

Names and ages of child's siblings if he/she has any_____

Whom may we thank for referring you to our office?_____

REASON FOR SEEKING CHIROPRACTIC CARE

How do you think we may help be able to help your child?_____

_____

Are these concerns affecting your child's activities of daily living? (Circle Y to those that apply)

Eating:	Y	N	Sleep:	Y	N	Running:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Relationships:	Y	N	Other:_____		

PREVIOUS CHIROPRACTIC CARE

Has your child ever received Chiropractic care? Y N Name of D.C._____

How long under care? _____days _____weeks _____ months _____years

Date of last visit:_____

FOR MOMS

Tell us about your pregnancy.

Did you carry full term? Y N If no explain._____

Describe any other complications if any. _____

Did you have any ultrasounds? Y N If yes, how many?_____

YOUR BABY AT BIRTH

Did you use a midwife? Y N Was your baby born at home, birthing center, or hospital?_____

Did you have a C-section? Y N Were there forceps used? Y N Vacuum Extraction? Y N

Did you have an epidural? Y N Was it a difficult birth? Y N

Explain if needed_____

_____

Hospital staff score a new born baby using an APGAR scale. It is taken at one minute after birth and again at five minutes after birth. If you happen to know your baby's score please write it in blanks, if not, the doctor may obtain this information from your child's birth record if necessary.

APGAR at one minute_____ at five minutes_____

TELL US MORE

Did you breastfeed? Y N How long?_____

Did you bottle feed the baby with formula? Y N What brand of formula?_____

Did you take any medication during your pregnancy? Y N

What medications and why?_____

As a baby or toddler, did any of the following occur?

___ fall from a changing table	___ frequent crying spells	___ frequent fevers
___ tumble from stair	___ fall out of crib	___frequent diarrhea
___involved in car accident	___constipation	___sleeping problems
___play in jumper	___frequent colds	___colic
___tonsillitis	___ fall off playground equipment	___ did not gain weight

___reaction to vaccination ___ other

Explain any of the above if needed_____

_____

Has your child ever had any vaccinations?_____

Did your child ever have any reactions to any vaccinations? _____

Has your child experienced any of the following?

___headaches	___numbness in arm/hands	___foot/ankle/knee pain
___dizziness	___arm/wrist pains	___tingling in arms/legs
___ringing in ears	___sleeping problems	___neck/back pain
___asthma	___allergies	___shoulder pains
___hyperactivity	___stomach problems	___growing pains
___fatigue	___weight gain or loss	___other_____

Which of the above that you checked would you consider the worst?_____

_____

Do any of the following still occur?_____

If yes, list which ones_____

Is this condition: ___constant ___intermittent ___occasional ___cyclic

QUALITY OF LIFE

When this condition is at its worst, how does it make your child feel?_____

_____

Is there anything you have done for your child regarding this condition that has NOT worked?_____

_____

Describe any hospital or emergency room stays?_____

_____

Approximately how many times have antibiotics been prescribed for your child and for what conditions.

_____

List any medications your child is currently taking: _____

_____

Is there anything else you think we should know about your child?_____

_____

EXPECTATIONS

I would like to have the following benefits for my teenager from Chiropractic Care: (check all that apply)

_____Relief of a symptom or problem

_____Relief and prevention of a symptom or problem

_____Healthier spine and nerve system

_____Optimal Health on all levels

YOUR INFORMED CONSENT

The information I have provided on this case history form, is true and accurate to the best of my knowledge. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know: 1. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported; 2. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause. Chiropractic care has been proven to be both, clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent and have had the opportunity to discuss it with my chiropractor. I have been informed and fully understand that Chiropractic care is not a treatment of any disease or condition. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of Curley Chiropractic. This consent applies to all present and future care for me and my family

Signature_____Date_____

Signature of Parent (for minor)_____Date_____

FINANCIAL REPSONSIBIILTY

CURLEY CHIROPRACTIC

In return for services rendered to me by Curley Chiropractic, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

Assignment of Benefits—I understand that Curley Chiropractic may or may not be a provider for my insurance company for services rendered at Curley Chiropractic quoted from my insurance carrier are only an estimate and not a guarantee of payment.

Medicare--- I acknowledge that Curley Chiropractic is a Medicare Provider and DOES accept Medicare Benefits.

Release of Medical Information and Records

By signing below I authorize Curley Chiropractic to release all medical information and/or records requested by my insurance company or any referring doctor. By signing below I also authorize Curley Chiropractic to use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment

Acknowledgment of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Curley Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary

_____ _____

Signature of Patient (or legal guardian) Date