CHIROPRACTIC first
FAMILY WELLNESS CENTER

CHILD'S INFORMATION FORM

Child's Name:_____ Parents' Names:_____
Address: _____ City:_____ State:_____ Zip:_____
Best Contact Number _____ Parent's Cell _____Email:_____
Birth Date: _____ Age: _____ Sex: M / F Current Weight:_____ Height:_____
Type of Birth: Vaginal_____ Cesarean_____ Breech_____ Forceps_____ Vacuum Extractor_____
Home_____ Birthing Center_____ Hospital _____ Length of labor_____
Problems during pregnancy_____
Problems during labor/delivery_____
Check all that apply concerning your labor:
Position during labor? On Back_____Side/sitting/standing_____ Monitoring? Internal_____ External_____
Receive drugs? Epidural_____ Morphine_____ Other_____
Induced Labor? YES / NO Episiotomy? YES / NO
Was your child subjected to: Drops in eyes? YES / NO Vitamin K? YES / NO
Hepatitis Shot? YES / NO Incubation? YES / NO If yes, how long? _____
Separation from you? YES / NO If yes, how long? _____
Congenital anomalies/defects:_____
Infant feeding: Breast _____ Formula _____
# of hours sleep per night:_____ Quality of sleep: Good _____ Fair _____ Poor_____
Obstetrician/Mid-Wife: _____
Pediatrician/Family MD:_____
Date of last visit to MD:_____ Purpose:_____
Vaccination History:_____
Why were shots given? _____
Has your child been treated on an Emergency Basis? _____
Describe: _____
Surgeries: _____
List any over the counter or prescription drugs your child is taking:_____
Has your child ever been under Chiropractic Care previously? YES / NO
If yes, Name of Chiropractor: _____
Has your child ever had a fall:Off change table:YES/NO, Out of a crib:YES / NO, Off a jolly jumper:YES/NO
Down stairs: YES / NO, Out of a tree: YES / NO, Off a bike: YES / NO
Has your child ever been in a car accident? YES / NO If yes, please describe:_____
_____
Purpose of today's appointment: _____

Chiropractic care is not a treatment or cure of disease. Chiropractic care is for the restoration and maintenance of full function and communication within the body, from the brain to every cell in the body, so that your child may express his/her full potential for life and healing. I understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my child's best interest. I have read this consent and intend this consent form to cover the entire course of my child's care and any care in the future. I hereby authorize this office and its doctor(s) to administer care as deemed necessary to my son/daughter _____ (name of child). I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Signature:_____ Witnessed:_____

Print Name: _____ Date: _____

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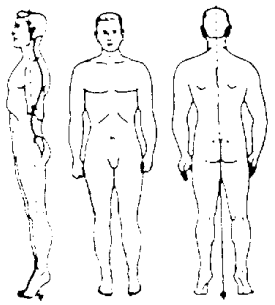
HEALTH HISTORY FORM

Patient's Name_____Date_____/_____/_____

*****If you are NOT experiencing ANY symptoms, please go to Section B: Health History*****

Section A: Current Problem Please answer the following questions regarding your **current** problem:

Please mark on the picture, where you have any problems.



Date of Onset: _____ Cause of Condition (if known)_____
How often during the day do you experience this?
☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%
Describe the pain: ☐ sharp ☐ dull ☐ achy ☐ stiff ☐ shooting ☐ burning ☐ spasm
How severe is this problem? No Pain 1 2 3 4 5 6 7 8 9 10 Extreme
Since the onset, is the pain? ☐ worse ☐ better ☐ same ☐ on & off
Is there anything that makes it worse? ☐ standing ☐ sitting ☐ lying down ☐ motion
Is there anything that makes it better? ☐ standing ☐ sitting ☐ lying down ☐ motion
Is this problem? ☐ Better or ☐ Worse ☐ AM or ☐ PM ☐ Neither
Are any systems involved? ☐ Digestive ☐ Cardiovascular ☐ Respiratory ☐ Elimination ☐ Reproductive
Does the pain cause you to? ☐ Lose sleep ☐ Be short tempered ☐ Miss work ☐ Miss play ☐ Lose focus
What has this problem kept you from enjoying? _____
Have you had a similar condition in the past? Y N If yes, explain: _____
What treatment(s) have you already had for this problem?
Medication Surgery Physical Therapy Chiropractic None Other:_____
What was the outcome of this treatment?_____
Any other facts about your current problem or pain: _____
_____
_____
Is there any chance you could be pregnant? YES NO Date of last menstrual period:_____

Section B: Health History (Please ✓ if you have had or are currently experiencing any of the following:)

☐ Anxiety	☐ Anemia	☐ Arthritis	☐ Thyroid Problems	☐ Bowel Problems
☐ Cancer	☐ HIV/AIDS	☐ Tuberculosis	☐ High Blood Pressure	☐ Heart Trouble
☐ Diabetes	☐ Hepatitis	☐ Insomnia	☐ Venereal Disease	☐ Muscular Dystrophy
☐ Epilepsy	☐ Dizziness	☐ Convulsions	☐ Multiple Sclerosis	☐ Rheumatic Fever
☐ Neuritis	☐ Asthma	☐ Scarlet Fever	☐ Digestive Problems	☐ Sinus Trouble
☐ Allergies	☐ Backaches	☐ Numbness	☐ Frequent Colds	☐ Nervousness
☐ Stroke	☐ Depression	☐ Headaches	☐ Cold Hands/Feet	☐ Restless Sleep
☐ Ulcer	☐ Irritability	☐ Impulsivity	☐ Low Pain Threshold	☐ Fibromyalgia
☐ Hernia	☐ PMS	☐ Bruising	☐ German Measles	☐ Osteoporosis
☐ Nausea	☐ Swelling	☐ Mood Swings	☐ Chronic Fatigue Syndrome	☐ Infertility

Describe other details about YOUR Past Medical History:_____
_____
_____

Section C: Family History (Your Blood Relatives Only)
☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Thyroid Problems ☐ Stroke ☐ Multiple Sclerosis
☐ Other: _____

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NOTICE OF PRIVACY FOR:
PATIENT'S PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.
This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Mailings for appointment reminders, birthday cards, bills and other correspondence.
- Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.
Please note the Doctors of Chiropractic First utilize an open area for the delivery of care and it is understood that if a patient/client needs to speak on a matter of personal privacy it is solely the responsibility of the patient to request a private area for the discussion to take place.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Dr. Andrew Williamson
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected by health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

_____	_____	_____
Name of Patient (print)	Signature of Patient/Legal Representative	Date