Child Member Health Record

ABOUT THE CHILD

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE: | GENDER:

HEIGHT: | WEIGHT:

SIBLINGS NAMES AND AGES:

GENERAL HISTORY

DOES YOUR CHILD EAT WELL ❑ YES ❑ NO

ARE YOU AWARE OF THE IMPACT NUTRITION CAN HAVE ON YOUR CHILD'S BEHAVIOR? ❑ YES ❑ NO

WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION FOR YOUR CHILD?
❑ YES ❑ NO

DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS ❑ YES ❑ NO

DOES YOUR CHILD SLEEP WELL ❑ YES ❑ NO

DOES YOUR CHILD SLEEP ON HIS/HER ❑ SIDE ❑ STOMACH ❑ BACK

PLEASE DESCRIBE HIS/HER SLEEPING HABITS:

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 MEDICATION/SUPPLEMENTS TAKEN:

LIST ANY ALLERGIES YOUR CHILD HAS :

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:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAS YOUR CHILD EVER BEEN CHECKED FOR VERTEBRAL SUBLUXATION?
❑ YES ❑ NO ❑ DON'T KNOW

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

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

CHIROPRACTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ❑ CONDITION ❑ WELLNESS
IF CONDITION, PLEASE DESCRIBE:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER

DID THIS CONDITION START:
❑ SUDDENLY ❑ GRADUALLY ❑ POST INJURY

WHAT DATE DID THIS CONDITION START?

IS THIS PROBLEM: ❑ OCCASIONAL ❑ FREQUENT ❑ CONSTANT

WHAT MAKES THIS PROBLEM BETTER?

WHAT MAKES THIS PROBLEM WORSE?

HAS THIS CONDITION:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ SLEEP ❑ DAILY ROUTINE ❑ EATING ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO

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

DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT/TESTING:

RESULTS:

Ballard Family Chiropractic
14225 E. Rickelman
Effingham, IL 62401

COMPLETE THIS PAGE FOR CHILDREN 4 to 8 YEARS OF AGE

BIRTH HISTORY

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? ❑ YES ❑ NO

DID YOU SUFFER ANY TRAUMAS, FALLS, OR ACCIDENTS? ❑ YES ❑ NO

PLEASE EXPLAIN:

DURING PREGNANCY DID YOU USE: ❑MEDICATIONS
❑ TOBACCO/ALCOHOL ❑ SUPPLEMENTS

IF YES, PLEASE LIST:

ULTRASOUND DURING PREGNANCY? ❑ YES ❑ NO NUMBER: _____

MEDICAL REASON FOR ULTRASOUND?

LOCATION OF BIRTH: ❑ HOME ❑ BIRTHING CENTER ❑ HOSPITAL

WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? _____ WEEKS

DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY:

❑DRUG FREE
❑ LABOR WAS CHEMICALLY INDUCED
❑ C-SECTION DELIVERY
❑ DOCTOR PULLED OR TWISTED BABY
❑SPONTANEOUS
❑ LABOR WAS DOCTOR ASSISTED
❑ FORCEPS/VACUUM EXTRACTION
❑ PREMATURE DELIVERY

PLEASE EXPLAIN:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT:

BIRTH LENGTH:

WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY ❑ YES ❑ NO

DID YOU BREASTFEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION? ❑ YES ❑ NO

DID YOU FORMULA FEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA?

❑BRUISNG
❑RESPIRATORY DISTRESS
❑FAST OR EXCESSIVELY LONG BIRTH
❑ODD SHAPED HEAD
❑ STUCK IN THE BIRTH CANAL
❑CORD AROUND NECK
❑LACK OF USE OF ONE ARM
❑ HEAD ROTATED TO ONE SIDE

GROWTH &DEVELOPMENT

DOES YOUR CHILD HAVE ANY DEVELOPMENTAL OR DEVELOPMOTOR DELAYS? ❑ YES ❑ NO

IF YES, PLEASE DESCRIBE AND INCLUDE INTERVENTIONS:

HOW MANY TIMES/WEEK DOES YOUR CHILD EAT FAST FOOD? _____

CANDY/COOKIES?_____ SODAS?_____

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?
❑ YES ❑ NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?

HOW MANY TIMES?:

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 ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

❑ YES ❑ NO

AT WHAT AGE DID YOUR CHILD START DAYCARE? _____

❑ IN-HOME ❑ DAYCARE CENTER

DOES YOUR CHILD ATTEND SCHOOL/PRESCHOOL? ❑ YES ❑ NO

DOES YOUR CHILD CARRY A BACKPACK? ❑ YES ❑ NO

WHAT IS THE APPROXIMATE WEIGHT?_____

AVERAGE NUMBER OF HRS OF TV/VIDEO GAMES PER WEEK ?_____

ARE THERE ANY SMOKERS LIVING IN THE HOME? ❑ YES ❑ NO

ARE THERE ANY INDOOR PETS IN YOUR HOME? ❑ YES ❑ NO

DO YOU USE GREEN CLEANING PRODUCTS IN YOUR HOME? ❑ YES ❑ NO

COMPLETE THIS PAGE FOR CHILDREN 4 TO 8 YEARS OF AGE

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT CHIROPRACTIC IS THE LARGEST ALTERNATIVE HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

ARE YOU AWARE THAT CHIROPRACTORS TREAT A CONDITION CALLED SUBLUXATION?
❑ YES ❑ NO

DID YOU KNOW THAT YOU CAN HAVE A SUBLUXATION WITHOUT EXPERIENCING PAIN?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ YES ❑ NO

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____ ❑ M ❑ F ❑ S ❑ G

DEPRESSION ❑ M ❑ F ❑ S ❑ G

DIABETES ❑ M ❑ F ❑ S ❑ G

HEART DISEASE ❑ M ❑ F ❑ S ❑ G

LIVER DISEASE ❑ M ❑ F ❑ S ❑ G

HIGH CHOLESTEROL ❑ M ❑ F ❑ S ❑ G

HIGH BLOOD PRESSURE ❑ M ❑ F ❑ S ❑ G

LUNG PROBLEMS ❑ M ❑ F ❑ S ❑ G

SEIZURES ❑ M ❑ F ❑ S ❑ G

NECK PROBLEMS ❑ M ❑ F ❑ S ❑ G

BACK PROBLEMS ❑ M ❑ F ❑ S ❑ G

SCOLIOSIS ❑ M ❑ F ❑ S ❑ G

OSTEOARTHRITIS ❑ M ❑ F ❑ S ❑ G

RHEUMATOID ARTHRITIS ❑ M ❑ F ❑ S ❑ G

AUTOIMMUNE DISEASES ❑ M ❑ F ❑ S ❑ G

OTHER:_____

SYSTEMS REVIEW

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS/SYMPTOMS YOUR CHILD HAS EXPERIENCED:

❑ ACID REFLUX
❑ BED WETTING
❑ CONSTIPATION
❑ EAR INFECTIONS
❑ DIARRHEA
❑ COLIC
❑ ASTHMA
❑ POOR COORDINATION
❑ BRONCHITIS
❑ SLEEPING DIFFICULTIES
❑ NECK PAIN
❑ LOW BACK PAIN
❑ DIFFICULT WEIGHT GAIN
❑ LEARNING DISORDERS
❑ DIARRHEA
❑ FREQUENT COLDS/COUGHS/FLUS
❑ HYPERACTIVITY
❑ HEADACHES
❑ FEVERS
❑ SORE THROATS
❑ ALLERGIES
❑ URINARY PROBLEMS
❑ UPPER BACK PAIN
❑ SHORTNESS OF BREATH

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1._____

_____

2._____

_____

3._____

_____

WHAT CHANGES (IF ANY) WOULD YOU LIKE TO SEE ACCOMPLISHED IN YOUR CHILD'S HEALTH OR BEHAVIOR?

IF YOU HAVE ANY OTHER CONCERNS NOT PREVIOUSLY LISTED ON THESE FORMS, PLEASE WRITE THEM IN U SING THE SPACE BELOW.

THANK YOU FOR CHOOSING BALLARD FAMILY CHIROPRACTIC AND HELPING US TO CONTINUE ON OUR MISSION TO
GROW A HEALTHIER COMMUNITY, ONE FAMILY AT A TIME!

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

To receive text appointment reminders initial here _____

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

AUTHORIZATION FOR CARE OF A MINOR AND FINANCIAL AGREEMENT

I hereby authorize the doctors in this chiropractic office to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Please read each statement and initial.

- I understand that I am personally financially responsible for all services rendered to me or my child. _____
- I agree that all fees will be paid at the time of service unless arrangements have been made in advance with Ballard Family Chiropractic. _____
- I understand if I carry a balance, a card must be kept on file with an authorization for a monthly payment as agreed upon with Ballard Family Chiropractic._____
- I understand if my balance exceeds $500 care may be suspended until financial arrangements have been made. _____
- Ballard Family Chiropractic has a $25 no show fee to be applied at staff discretion for missing appointments without appropriate notification or cancellation. _____

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE: