STRAND SPINE INSTITUTE

Skilled. Compassionate. Preferred.

CHILD MEMBER HEALTH FORM

ABOUT THE CHILD

Patient Name:	
Address:	
City:	State/Zip:
Home phone:	
DOB:	Age:
Gender:	Weight:

ABOUT THE PARENT

Parent/Legal Guardian Name:	
Are you the parent or legal guardian:	
Marital Status:	
Address:	
City:	State/Zip:
Home Phone:	Cell Phone:
Email Address:	
Employer Name:	
Employer Address:	
Employer City:	Employer State/Zip:
Work Phone:	Position Title:

CHIPROPRACTIC EXPERIENCE

Who referred you to our office?

How did you hear about us?

Has any member of your family ever seen a chiropractor?

MEDICATIONS / VACCINATIONS

Number of doses of prescription medication child has taken during his/her lifetime:

Please list all medications:

Have you chosen to vaccinate your child?

□ Yes □ No

If yes, please check all that apply:

□ DPT □ MMR □ Chicken Pox □ Hepatitis □ Other

Describe any and all reactions to vaccines:

REASON FOR THIS VISIT

Describe the reason for this visit:

□ Wellness □ Condition (please explain)

Is the purpose of this appointment 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 (please explain)

Has this condition occurred before? □ Yes □ No (please explain):

© Copyright FreeForm Chiro, LLC. All rights reserved.

Have you seen other doctors or chiropractors for this condition?
□ Yes □ No

Doctor's name:

Type of treatment:

Results:

Complete for Children Infant to 5 years

PRENATAL HISTORY

During pregnancy did you use:

□ Drugs/Medication (please describe below) □ Tobacco/Alcohol

Location of birth:
□ Home □ Birthing Center □ Hospital

Describe your delivery:
□ Labor was chemically induced □ C-Section Delivery
□ Premature delivery □ Forceps/Vacuum
□ Labor was doctor assisted

Describe any complications experienced during delivery:

Did you experience any illness(s) while pregnant:
□ Yes □ No (please explain)

Please describe any genetic disabilities:

Birth Weight:

Birth Length:

Apgar Scores:

Ultrasound during pregnancy? □ Yes □ No □ Number____

Did you breastfeed the baby? □ Yes □ No □ how long ____

Did you formula feed the baby?
□ Yes □ No □ how long ____

Are you aware of any food or juice allergies or intolerance?
□ Yes □ No

At what age did you introduce:

Solids:

Cow's milk:

LIFESTYLE HABITS

Does your child exercise daily?
□ Yes □ No □ how much? _______

Does your child drink soda?
□ Yes □ No □ how much? _______

Does your child take vitamins? □ Yes □ No □ list them

Does your child do affirmations? □ Yes □ No

Does your child watch more than an hour of TV per day?
□ Yes □ No □ how much? _______

Does your child eat balanced meals?
□ Yes □ No

Does your child experience prolonged sadness?
□ Yes (explain) □ No

CHILD'S 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 for care.*

□ Asthma	□ Diarrhea
□ Bed Wetting	□ Ear infections
□ Bronchitis	□ Headaches
□ Constipation	□ Hyperactivity
□ Learning Disorders	□ Sore throat
□ Nervousness	□ Upset stomach
□ Urinary Infections	

CURRENT HEALTH STATUS

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 hospitalized or had surgery?

□ Yes □ No (please explain)

Has your child ever been in a car accident?

□ Yes □ No (please explain)

Does your child have difficulty interacting with others?

□ Yes □ No (please explain)

Strand Spine Institute
12465 Ocean Highway Pawleys Island, SC 29585
(843) 979-2273 fax (843) 235-3427

© Copyright FreeForm Chiro, LLC. All rights reserved.

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

□ Yes □ No (please explain)

Complete for Children 5-10 years

LIFESTYLE HABITS

Does your child exercise daily?
□ Yes □ No □ how much? _______

Does your child drink soda?
□ Yes □ No □ how much? _______

Does your child have difficulty sleeping?
□ Yes □ No □ list them

Does your child play video games? □ Yes □ No

Does your child watch more than an hour of TV per day?
□ Yes □ No □ how much? _______

Does your child eat balanced meals?
□ Yes □ No

Does your child experience prolonged sadness?
□ Yes (explain) □ No

CHILD'S 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 for care.*

□ Asthma	□ Diarrhea
□ Bed Wetting	□ Ear infections
□ Bronchitis	□ Headaches
□ Constipation	□ Hyperactivity
□ Learning Disorders	□ Sore throat
□ Nervousness	□ Upset stomach
□ Urinary Infections	

CURRENT HEALTH STATUS

Has your child been involved in any high impact/contact type sports (i.e.: soccer, football, martial arts, cheerleading, etc.)

□ Yes □ No Please list:

Has your child ever been hospitalized or had surgery?
□ Yes □ No (please explain)

Has your child ever been in a car accident?
□ 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 (please explain)

Complete for Children 11-18 years

LIFESTYLE HABITS

Does your child exercise daily?
□ Yes □ No □ how much? _______

Does your child drink soda?
□ Yes □ No □ how much? _______

Does your child have difficulty sleeping?
□ Yes □ No □ list them

Does your child play video games? □ Yes □ No

Does your child watch more than an hour of TV per day?
□ Yes □ No □ how much? _______

Does your child eat balanced meals?
□ Yes □ No

Does your child experience prolonged sadness?
□ Yes (explain) □ No

CHILD'S 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 for care.*

□ Anxiety	□ Hips, knees, ankles
□ Asthma	□ Hyperactivity
□ Back pain stiffness	□ Learning disorders
□ Constipation	□ Neck stiffness/pain
□ Diarrhea	□ Shoulders elbow, wrist
□ Depression	□ Stress
□ Difficulty irregular periods	□ Urinary infections
□ Headaches	

CURRENT HEALTH STATUS

Has your child been involved in any high impact/contact type sports (i.e.: soccer, football, martial arts, cheerleading, etc.)

□ Yes □ No Please list:

Has your child ever been hospitalized or had surgery?
□ Yes □ No (please explain)

12465 Ocean Highway Pawleys Island, SC 29585
(843) 979-2273 fax (843) 235-3427
© Copyright FreeForm Chiro, LLC. All rights reserved.

Has your child ever been in a car accident? □ Yes □ No (please explain)
Does your child have difficulty interacting with others? □ Yes □ No (please explain)

Please rate stress levels on a scale of 1-10 (10 being high)
School: 1 2 3 4 5 6 7 8 9 10
Personal: 1 2 3 4 5 6 7 8 9 10

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.

______________________________ ______________________________
Patient Name (print) Relationship to patient

______________________________ ______________________________
Signature Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when

© Copyright FreeForm Chiro, LLC. All rights reserved.

the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

____ ______________________________
Signature Date

____ ______________________________
Witness Signature Date

AUTHORIZATION FOR CARE OF A MINOR

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever 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 Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

____ ______________________________
Parent or Guardian Authorizing Care Signature Date

© Copyright FreeForm Chiro, LLC. All rights reserved.