1632 N. 18th Street
Manitowoc, WI 54220
(920) 652-0116

PATIENT HEALTH RECORD - CHILD

ABOUT THE CHILD

Name _____

Address _____

City_____ Sate_____Zip _____

Home Phone _____

Birthdate _____

SS#_____

Age _____ Gender _____ Weight_____

ABOUT THE PARENT

Name _____

Employer _____

Employer Address _____

Employer Phone _____

Email _____

SS# _____

Marital Status _____

Spouse's Name_____

Payment method: ☐ Cash ☐ Check ☐ Credit Card

VACCINATIONS

Have you chosen to vaccinate your child? Yes No

If yes, please check vaccinations received:

☐ DPT ☐ MMR ☐ Chicken Pox ☐ Hepatitis
☐ Other

Describe any and all reactions to vaccines:

_____
_____
_____

PATIENT CONDITION

Reason for visit:_____
_____

When did symptoms appear? _____

Has the condition gotten progressively worse?
☐ Yes ☐ No ☐ Unknown

How often does the child have this pain? _____

Does this condition interfere with any of the following:
☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Laying Down

Is the purpose of this appointment related to any of the following:
☐ Sports ☐ Auto Accident ☐ Fall ☐Home injury ☐Other
Please explain _____

Has this condition occurred before? Yes No
Please explain _____

Has the child seen other doctors for this condition? Yes No

Doctor's Name (s) _____

Type of treatment_____

Results_____

EXPERIENCE WITH CHIROPRACTIC

Whom may we thank for referring you?_____

Has the child been adjusted by a chiropractor before?_____

Doctor's Name:_____

Reason for visit:_____

Approximate date of last visit:_____

Have any other members of your family been under chiropractic care? If so, what for?_____
_____

YOUR CHILD'S HEALTH HISTORY

Please check (√) all symptoms your child has had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Hyperactivity ADD / ADHD
- ☐ Attention Problems
- ☐ Skin problems
- ☐ Constipation
- ☐ Digestive Problems
- ☐ Other: _____
- ☐ Bed Wetting
- ☐ Allergies
- ☐ Irritability
- ☐ Colic
- ☐ Ear Infections
- ☐ Vision Problems
- ☐ Frequent Colds
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Sleeping Problems
- ☐ Tubes in Ears
- ☐ Moodiness / Mood swings

MOTHER'S PREGNANCY & LABOR CHILD'S CURRENT HEALTH STATUS

Why this section is important: Here at Advanced Family Chiropractic, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. We experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential, on a daily basis. Most often, the effects are gradual, where they are not experienced until they become serious. Answering the following questions will give us a profile of the specific stresses you and your child have faced, allowing us to better assess the challenges to your health potential.

Please answer the following questions the best you can:

Did your child experience any physical injuries? (falls, car accidents, etc)	Yes	No	Unsure	Did you suffer traumas (physical or emotional) during pregnancy?	Yes	No	Unsure
Is your child "accident prone"?	Yes	No	Unsure	Was your delivery chemically induced, C-section, forceps, or vacuum assisted?	Yes	No	Unsure
Did/does your child play youth sports?	Yes	No	Unsure	Did/do you nurse the baby? If Yes, for how long? _____	Yes	No	Unsure
Has your child fallen/jumped from a height over three feet? (i.e. crib, bunk bed , trees)	Yes	No	Unsure	Did/does your baby have colic?	Yes	No	Unsure
Current / past use of medicine, such as antibiotics or an inhaler?	Yes	No	Unsure	Have you noticed any nervousness, twitches, shakes or rocking?	Yes	No	Unsure
Did you take/use any drugs during your pregnancy? (OTC medicine/tobacco/alcohol)	Yes	No	Unsure	Did/does your child have difficulty interacting with others?	Yes	No	Unsure

AWARENESS WITH CHIROPRACTIC PRINCIPLES

Were you aware that:	YES	NO		YES	NO
Doctors of Chiropractic work with the nervous system?	☐	☐	Chiropractic is the largest natural healing profession in the world?	☐	☐
The nervous system controls all bodily functions and systems?	☐	☐	If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐	☐

GOALS FOR MY CHILD'S CARE

People see Chiropractors for a variety of reasons. We will weigh your needs and desires when recommending your care plan. Please check ✓ the type of care desired.

☐ Relief Care – Symptomatic relief of pain or discomfort
☐ Corrective Care – Correcting and relieving the *cause* of the problems, as well as the symptoms
☐ Comprehensive Care – To bring any malfunctions in the body to the highest state of health possible
☐ I want the Doctor to select and recommend the type of care appropriate for my child

AUTHORIZATION FOR CARE OF MINOR CHILD

I am the parent and/or legal guardian of this child and have the ability to make medical decisions on behalf of this child. I have elected to seek care for him/her at *Advanced Family Chiropractic* for the conditions described in this form and for overall enhanced wellness of this child.

I hereby authorize the doctors of *Advanced Family Chiropractic* and their staff to administer chiropractic care to my minor child including chiropractic adjustments, therapies, and any examination or diagnostic procedures needed to adequately treat him/her. The doctors will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I agree to be an informed partner in the treatment of my child.

I understand that the chiropractic method of correction of subluxation is by specific adjustments to the joints of the body. The clinic does not offer to diagnose or treat any disease or condition other than vertebral subluxation. If they encounter non-chiropractic or unusual findings, I will be advised so that I can seek the services of a health care provider that specializes in that area.

studies show ...
Chiropractic Kids are Healthier!

_____
Signature of Parent, Guardian or Personal Representative

****Will another guardian/family member be accompanying your child to his/her appointments? If so, please list their name(s) and relation to child.**_____

PAYMENT INFORMATION

How will payment be made? ☐ Self / Cash ☐ Health Insurance ☐ Auto/Injury Insurance ☐ School Insurance ☐ Medicare ☐ Medicaid/BadgerCare ☐ Other: _____

Carrier Name: _____

Primary Insured: (if not you): _____ DOB: _____

Insurance SSN or Group # _____

Date of Injury (If applicable): _____ Claim #_____

Auto Insurance Name: _____ Attorney Name:_____

INSURANCE ASSIGNMENT & RELEASE OF RECORDS

I certify that I, and /or my dependent(s), have insurance coverage with the above Carrier and assign directly to Advanced Family Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Advanced Family Chiropractic may use my health care information and may disclose such information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I hereby authorize the doctors at *Advanced Family Chiropractic* to perform an examination, including x-rays if indicated, and to provide chiropractic services to me (or my dependants) based on the information provided herein.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____
Please **Print Name** of Parent, Guardian or Personal Representative

OFFICE OPTIONS:

☐ YES ☐ NO Please Text or Email me appointment reminders when needed
____Text Cellular Provider name:_____
____Email Email address:_____

☐ YES ☐ NO I would like to discuss payment options in order to afford care

☐ YES ☐ NO I am interested in long-term wellness for my family

Visit us online at www.manitowochealth.com
Find us on Facebook

Advanced Family Chiropractic
1632 N 18th Street
Manitowoc WI 54220
920.652.0116

Electronic Health Records Child Intake Form

This form complies with CMS EHR incentive program requirements

Child's First Name:_____ **Child's Last Name:**_____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Family Medical History *(Record one diagnosis in your family history and the affected*				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Is child currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Does child have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of patient's clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Parent/Guardian Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____