CHILD MEMBER HEALTH RECORD

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):

❑ FACEBOOK ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ FRIEND

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?

❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:

ADDRESS:
❑ SAME AS ABOVE

CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

EMPLOYER ADDRESS:

EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

DOES THIS CHILD HAVE MEDICAID? Y N

IS THIS AN AUTO CLAIM? Y N

VACCINATIONS/MEDICATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:

❑ DPT ❑ MMR ❑ CHICKEN POX ❑ HEPATITIS ❑ OTHER

DATE OF LAST VACCINATION:

LIST PRESCRIPTION MEDICATION & # OF DOSES CHILD HAS TAKEN:

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN IN THE LAST:

6 MONTHS _______________, TOTAL DURING LIFETIME __________________

ABOUT THE CHILD

NAME:

ADDRESS:

CITY:	STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH:	AGE:

SOCIAL SECURITY NUMBER:

GENDER:	WEIGHT:
BIRTHPLACE:	

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

❑ WELLNESS ❑ CONDITION

IF CONDITION, DESCRIBE:

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 ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?

❑ YES ❑ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?

❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

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	❑ EAR INFECTIONS	❑ NECK STIFFNESS/ PAIN
❑ BACK PAIN/ STIFFNESS	❑ HEADACHES	❑ SHOULDERS/ELBOW/WRITST PAIN
❑ BED WETTING	❑ HIPS, KNEES, ANKLES	❑ UPSET STOMACH
❑ BRONCHITIS	❑ HYPERACTIVITY	❑ SORE THROAT
❑ CONSTIPATION	❑ LEARNING DISORDERS	❑ UPSET STOMACH
❑ DIARRHEA	❑ NERVOUSNESS	❑ URINARY INFECTIONS
❑	❑	❑

CHILD'S CURRENT HEALTH STATUS

DURING PREGNANCY DID YOU USE:

❑ DRUGS/MEDICATIONS ❑ TOBACCO/ALCOHOL

IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR DELIVERY:

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

PLEASE EXPLAIN:

DESCRIBE ANY COMLICATIONS EXPERIENCED DURING DELIVERY:

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ 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:

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)

❑ YES ❑ NO

PLEASE LIST:

ALL ABOUT POTENTIAL Family Chiropractic, PC

Helping Create Extraordinary Lives

Scott A. Hourigan, D.C. | Dawn M. Hourigan, D.C. | Jesse T. Kimball, D.C. | Marina Kimball, D.C.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Chiropractic: It is a distinct science, art and philosophy dealing with the detection, location, control, reduction and correction of vertebral subluxation. A profession dealing with the cause, not the symptom.

Spinal Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction, done by hand, is a specific adjustment of the spine.

Optimum Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. This can only be accomplished with a proper functioning nerve system.

Vertebral Subluxation: Also known as the silent killer. A misalignment of one of more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's God given ability to express its maximum health potential.

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 examination, 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 another health care provider.

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 God given wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I have read and fully understand the above statements.
All 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)

Consent to evaluate and adjust a minor child

I, being the parent or legal guardian of____________________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:____________________

____ ___________________________

(Signature) (Date)

18 YEARS OF EXPERIENCE
Palmer Graduates | Gonstead Chiropractic
311 N 27th St, Suite 1 | Spearfish, SD 57783 | 605.644.9074

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We care about out patients' privacy and strive to protect the confidentiality of your health information at this practice.

New federal legislations request that we issue this official notice of our privacy practices. You have the right to the confidentiality of your health information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

Please sign on the line below, signifying that you have been notified of this Privacy Notice and can obtain a written copy upon request.

____________________ ____

(Date) (Signature)