Child Member Health Record

Patient Information

Child's First Name: Child's Last Name: Date:

Date of Birth: Age: Sex: ◯ Male ◯ Female Phone: - - cell/home

◯ Check if you want text reminders for apts.

Guardian's Name(s):

Street Address: Height: ft in

City: State: Zip: Weight:

Email: Insurance Company:

Employers Name: Address: Phone: - -

Emergency Contact: Relation: Phone: - -

How did you hear about our office? If you were referred in, who referred you to our office?

Who is your child's primary care physician? Date and reason for last visit:

Is your child receiving care from any other health care provider? ◯ Yes ◯ No What is their specialty?

Please note any significant medical history:

Current Health Conditions

What health condition(s) bring your child to our office?

Has your child ever received care for the condition before? ◯ Yes ◯ No If yes, please explain:

When did the condition(s) begin?

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is the condition? ◯ Getting Worse ◯ Staying the same ◯ Improving ◯ Come and Gone ◯ Unsure

What makes the condition better? What makes the condition worse?

The condition(s) interferes with: ◯ Sleep ◯ Daily Routine ◯ Other Activities

Please Explain:

Chiropractic Experience

Has your child ever been adjusted by a chiropractor? ◯ Yes ◯ No If so, what was the reason for those visits?

Doctor of Chiropractics Name? Approximate Date of Last Visit:

What would you like to gain from chiropractic care? ◯ Resolve Existing Condition(s) ◯ Overall Wellness ◯ Both

Last Name, First Name:

Pregnancy & Labor History

Did you smoke? ○ Yes ○ No

Did you drink alcohol? ○ Yes ○ No

Did you take any medications? ○ Yes ○ No Please List:

Did you drink coffee, tea, or soda? ○ Yes ○ No

Did you exercise regularly? ○ Yes ○ No

Child's Birth: ○ Natural/Vaginal ○ Scheduled C-Section ○ Emergency C-Section At how many weeks was child at birth?

Please check any complications/interventions during birth:

○ Breach ○ Induction ○ Pain Meds ○ Epidural ○ Vacuum Extraction ○ Forceps ○ Other:_____

Child's Growth & Development

Was your child breast fed or formula fed? ○ Breast Fed ○ Formula Fed

Did/does your child ever suffer from colic, constipation, or reflus as an infant? ○ Yes ○ No

Youth or College Sports Injury? ○ Yes ○ No If yes, explain:

Any Auto Accidents? ○ Yes ○ No If yes, explain:

Please list your child's hospitalization and surgery history:

Please list any major injuries, accidents, concussions, falls and/or fractures your child has sustained in his/her lifetime:

Has your child suffered from night terrors? ○Yes ○No If yes, please explain:

How would you describe your child's diet? ○ Mostly whole foods ○ Pretty average ○ Mostly processed foods

How many hours a day does your child typically spend on a TV, phone, tablet, and/or computer?

Health Conditions

Please **CIRCLE** each of the conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.

Constipation	Ear Infections	Attention Problems	Anxiety	Allergies	Ashtma
Breathing Problems	Bed Wetting	Digestive Problems	Colic	Headaches	Frequent Colds
Skin Problems	Upper Respiratory Issues	Other:_____			

Last Name, First Name:

Medications

Is your child currently taking any medications? ◯ Yes ◯ No If yes, please list:

Please list any vitamins or supplements that you take on a regular basis:_____

_____

Has your child taken antibiotics? ◯ Yes ◯ No If yes, how many times and what for?

Health Goals

What are you top three health goals for your child:

1._____

2._____

3._____

Authorization For Care Of a Minor

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate such as mobility, massage, and any therapy the doctor seems appropriate as discussed with parent. I clearly understand and agree that all services rendered by my child 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. Nye & the Doctors of Woodbury Spine will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Woodbury Spine Wellness Center, LLC directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

Name of Child:

Parent or Guardian Authorizing Care's Name (please print): Birthdate:

Signature of Parent or Guardian: Date:

Signature: Date:

Last Name, First Name:

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 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 subluxations. 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 question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: Date:

Witness' Signature: Date:

Payment Agreement/Use of Insurance Authorization

I hereby authorize the Doctors of Woodbury Spine Wellness Center to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by 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. Woodbury Spine Wellness Center will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Woodbury Spine Wellness Center, LLC for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Woodbury Spine Wellness Center will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Woodbury Spine Wellness Center, LLC will be credited to my account upon receipt.

Signature: Date:

Guardian/Authorized Person of Care Signature: Date:

Who should receive bills for payment on your account?

○ Patient ○ Spouse ○ Parent ○ Workers Comp ○ Auto Insurance ○ Medicare ○ Health Insurance

Date of Birth:

Insurance Company: ID# Group ID:

Last Name, First Name:

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

Address:

Phone:

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

1. A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
2. B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
    1. Mental health records
    2. Communicable diseases (including HIV and AIDS)
    3. Alcohol/drug abuse treatment
    4. Other (please specify):
    5. _____
    6. _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

1. An electronic record or access through an online portal
2. Hard copy

This authorization shall be effective until (Check one):

1. All past, present, and future periods, OR
2. Date or event:_____
   unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of Individual Giving this Authorization (please print): Date of Birth:

Signature of Individual Giving this Authorization: Date:

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524