



Child Member Health Record

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
PARENT EMAIL	
DATE OF BIRTH:	AGE:
GENDER	
HEIGHT	WEIGHT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
WORK PHONE:	
EMPLOYER NAME:	
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

VACCINATIONS/MEDICATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
LIST PRESCRIPTION MEDICATIONS & # OF DOES CHILD HAS TAKEN:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> WELLNESS <input type="checkbox"/> CONDITION
IF CONDITION, DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

CHILD'S CURRENT HEALTH

HOW MANY ROUNDS OF ANTIBIOTICS HAS YOUR CHILD TAKEN? _____
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT DISLOCATION?
 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:

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:

DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT? 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:

PLEASE RATE YOUR CHILD'S STRESS LEVELS ON A SCALE OF 1-10 (10=HIGH)
SCHOOL: 1 2 3 4 5 6 7 8 9 10
PERSONAL: 1 2 3 4 5 6 7 8 9 10
PLEASE EXPLAIN:

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

CHILD'S HEALTH HISTORY

INSTRUCTIONS: Please check each of the 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.

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY/PAINFUL/IRREGULAR PERIODS	<input type="checkbox"/> NECK STIFFNESS/PAIN
<input type="checkbox"/> BACK PAIN/STIFFNESS	<input type="checkbox"/> SLEEPING DIFFICULTIES	<input type="checkbox"/> SHOULDERS, ELBOW, WRIST PAIN
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> HIPS, KNEES, ANKLES	<input type="checkbox"/> STRESS
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS
<input type="checkbox"/> HEADACHES	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> ASTHMA

NUTRITION

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET? YES NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE FOOD ALLERGIES? YES NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURRING SKIN RASHES? YES NO
PLEASE EXPLAIN:

DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS? YES NO
PLEASE EXPLAIN:

DOES YOUR CHILD ELIMINATE STOOLS EACH DAY? YES NO
PLEASE EXPLAIN:

WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?

WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?

WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?

WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?

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 was offered a copy of the Notice of Patient Privacy Policy, but **declined** it _____ Parent Initials **OR**
 I have received a copy of the full Notice of Patient Privacy Policy _____ Parent Initials

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 (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
PARENT OR GUARDIAN SIGNATURE:	DATE:

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Ranae Beard to administer chiropractic care, to work with my child, _____, and their condition through the use of adjustments and procedures that the doctor deems appropriate. I clearly understand and agree that all services rendered to 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 Doctor 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 child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

It is understood and agreed that the payments to the Doctor for X-rays is for examination and diagnosis. They are kept on digital file for 7 years where they may be seen at any time while I am a patient at this office. I can request a copy of my X-rays for a \$5 fee. I can request a digital copy of my records for no charge, but if you want a paper copy there will be a charge depending on the number of pages.

I authorize the use of this signature to allow the insurance companies to pay Access to Health directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

It is our desire to post the pictures of our children patients, along with their first name and age, in our reception room to encourage parents to consider chiropractic care for their children. Please initial if you authorize this: _____

CHILD'S NAME:

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

ACCESS TO HEALTH, PC
3113 S Taft Hill RD
Fort Collins, CO 80526
970-530-0981

I, _____, hereby consent and state my preference to have my physician, Ranae Beard, DC, and the Access To Health team communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to email me a monthly newsletter (which gives me information about days closed, product of the month & health tips). We don't give out your email to ANYONE!

Email _____

I give permission to contact me, relative to appointment reminders, by text message twice: I will receive a message the day before and 2 hours before my appointment. **Text messages** to the following **CELL** number _____

I give my permission to leave a message about my private health information at the following phone number _____

Parent Signature _____

For my child _____

Date _____