CHILD MEMBER HEALTH RECORD

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT 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:
INSURANCE COMPANY:	
INSURED'S NAME	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH	

VACCINATIONS

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

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:
❑ DPT ❑ MMR ❑ CHICKEN POX ❑ HEPATITIS ❑ OTHER

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECASE OF (ALL THAT APPLY):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

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:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

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 FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

Synergy Chiropractic
www.forhealthforlife.com
937-748-8770

MOTHER'S PREGNANCY & LABOR

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 ❑ FORCEPTS/VACUUM EXTRACTION
❑ DOCTOR PULLED OR TWISTED BABY ❑ PREMATURE DELIVERY
PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?
❑ YES ❑ NO
PLEASE EXPLAIN:

DID YOU NURSE THE BABY?	❑ YES	❑ NO
DID YOU EXPERIENCE FEEDING PROBLEMS?	❑ YES	❑ NO
DID YOUR BABY HAVE COLIC?	❑ YES	❑ NO
VACCNATIONS?	❑ YES	❑ NO

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or had 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.*

❑ ALLERGIES	❑ CONSTIPATION	❑ IRRITABILITY
❑ ASTHMA	❑ DIGESTIVE PROBLEMS	❑ SKIN PROBLEMS
❑ ATTENTION PROBLEMS	❑ EAR PROBLEMS	❑ SLEEPING DISORDERS
❑ BED WETTING	❑ FREQUENT COLDS	❑ TUBES IN THE EARS
❑ BREATHING PROBLEMS	❑ HEADACHES	❑ VISION PROBLEMS
❑ COLIC	❑ HYPERACTIVITY	❑ OTHER:

CHILD'S CURRENT HEALTH STATUS

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

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SEVERE FALL? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO
PLEASE EXPLAIN:

IS YOUR CHILD ACCIDENT PRONE? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ❑ YES ❑ NO
PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ❑ 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:

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

CHIROPRACTIC AWARENESS

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ❑ YES ❑ NO	THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❑ YES ❑ NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO	IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ❑ YES ❑ NO

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. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I authorize the use of this signature to allow the insurance companies to pay (PRACTICE NAME) directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

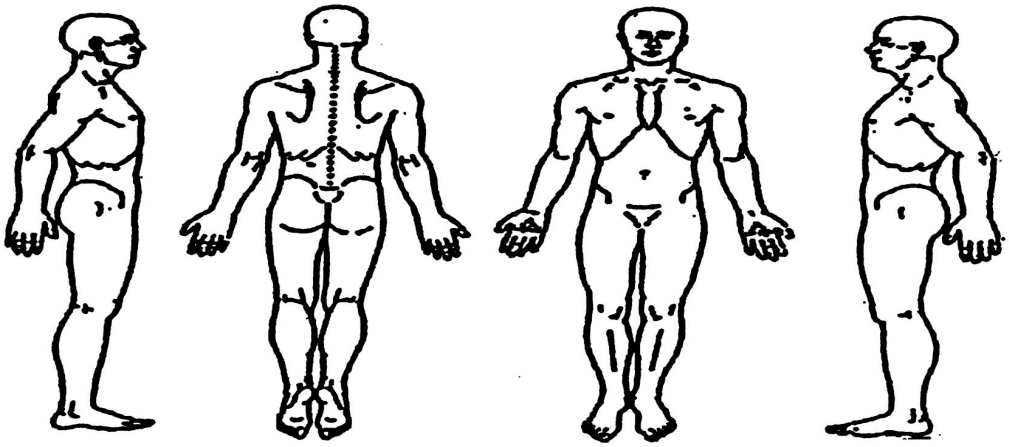
PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Age _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____