

# CHILD MEMBER UPDATE RECORD

## ABOUT THE CHILD

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

## CHIROPRACTIC EXPERIENCE

|  |
|--|
| WHEN WAS YOUR LAST CHIROPRACTIC ADJUSTMENT?                  |
| WHAT WAS THE REASON FOR THE VISITS?                          |
| DOCTOR'S NAME:   |
| APPROXIMATE DATE OF LAST VISIT:                              |
| HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?       |
| HAS ANY OTHER CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR? |

## ABOUT THE PARENT

|  |                          |
|--|--------------------------|
| PARENT NAME:                                       |                          |
| ADDRESS:<br><input type="checkbox"/> 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:                           |                          |

## REASON FOR THIS VISIT

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

## VACCINATIONS

|   |
|---|
| HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO   |
| IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:<br><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):  |

# CHILD MEMBER UPDATE RECORD

## MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:  
 DRUGS/MEDICATIONS       TOBACCO/ALCOHOL  
 IF YES, PLEASE EXPLAIN:

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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:

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

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DID YOU NURSE YOUR BABY?       YES       NO

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DID YOU EXPERIENCE FEEDING PROBLEMS?       YES       NO

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DID YOUR BABY HAVE COLIC?       YES       NO

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VACCINATIONS?       YES       NO

## CHILD'S CURRENT HEALTH STATUS

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

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

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

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

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IS YOUR CHILD ACCIDENT PRONE?       YES       NO  
 PLEASE EXPLAIN:

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

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IS YOUR CHILD CURRENTLY TAKING MEDICATIONS?       YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?  
 YES       NO  
 PLEASE EXPLAIN:

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HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS,  
 TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?  
 YES       NO  
 PLEASE EXPLAIN:

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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 diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall care plan and the possibility of being accepted for care.*

|   |   |   |
|---|---|---|
| <input type="checkbox"/> ALLERGIES          | <input type="checkbox"/> CONSTIPATION     | <input type="checkbox"/> IRRITABILITY       |
| <input type="checkbox"/> ASTHMA             | <input type="checkbox"/> DIGESTIVE ISSUES | <input type="checkbox"/> PAIN               |
| <input type="checkbox"/> ATTENTION PROBLEMS | <input type="checkbox"/> EAR PROBLEMS     | <input type="checkbox"/> SKIN PROBLEMS      |
| <input type="checkbox"/> BED WETTING        | <input type="checkbox"/> FREQUENT COLDS   | <input type="checkbox"/> SLEEPING DISORDERS |
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> HEADACHES        | <input type="checkbox"/> TUBES IN EARS      |
| <input type="checkbox"/> COLIC              | <input type="checkbox"/> HYPERACTIVITY    | <input type="checkbox"/> VISION PROBLEMS    |

## CHIROPRACTIC AWARENESS

|  |   |
|--|---|
| DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM.<br><input type="checkbox"/> YES <input type="checkbox"/> NO                | THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS.<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                   |
| CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD.<br><input type="checkbox"/> YES <input type="checkbox"/> NO | IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE.<br><input type="checkbox"/> YES <input type="checkbox"/> NO |

## AUTHORIZATION FOR CARE OF A MINOR

It is understood and agreed that the payments to the doctor for x-rays (if applicable) is for examination only. The x-ray films will remain the property of Healing Touch Chiropractic. 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 in order to work with my body through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered 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 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 Healing Touch Chiropractic directly any amounts payable as my assignment of benefits, if applicable. I authorize the use of this signature on any insurance submissions.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:

DATE:

# CHILD MEMBER UPDATE RECORD

## *Terms of Acceptance*

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve function through the adjustment of spinal subluxation(s).
- C. The chiropractic adjustment process, as defined in the “law of this jurisdiction” involves the application of a specific directional thrust to the spine.
- C. This is a safe, effective procedure applied over one-million times each day in the United States by doctors of chiropractic. Like all forms of health care, while offering considerable benefit, chiropractic may also provide some level of risk. This level of risk is minimal, yet injury can occur in rare cases.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type (s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, \_\_\_\_\_, have read and fully understand the above statements. I understand there may be risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# CHILD MEMBER UPDATE RECORD

## BENEFIT AUTHORIZATION

*I hereby authorize the Doctor to work with me through the use of adjustments to my spine, as he or she 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 Doctor will not be held responsible for any pre-existing 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 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 understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Healing Touch Chiropractic 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 Healing Touch Chiropractic will be credited to my account on receipt.*

SIGNATURE:

DATE:

SIGNATURE OF GUARDIAN OR SPOUSE AUTHORIZING CARE:

DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

SELF     SPOUSE     PARENT     WORKER'S COMP     AUTO INSURANCE     MEDICARE     HEALTH INSURANCE

## 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 care and follow up with multiple healthcare providers who may be involved in that care.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

*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:

SIGNATURE:

DATE:

**Healing Touch Chiropractic**  
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