PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Birth Date _____ Age _____

Gender _____ Weight _____

Height _____ Handed Right/Left _____

ABOUT THE PARENT

Name _____

Cell _____

Type of work _____

E-mail address _____

Insurance Co _____

Insured's Name: _____

DOB: _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to
❑ Sports ❑ Auto ❑ Fall ❑ Home Injury
❑ Wellness/Check Up ❑ Other

Please explain _____

When did this condition begin? _____

Has this condition
❑ gotten worse ❑ stayed constant ❑ comes and goes

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(s) _____

Type of treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No

Perline Chiropractic

212 -371-0700

920 3rd Ave, 6th Fl NY NY 10022 119 N Park Ave Ste 301 RVC NY

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

❑ Drugs / Medicine ❑ Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy?_____

_____

How was your delivery?

❑ Labor chemically induced ❑ Labor was Dr. assisted
❑ C-section delivery ❑ Forceps/Vacuum extraction
❑ Premature delivery

Please explain _____

Did you nurse your baby? ❑ Yes ❑ No

Did your baby have colic? ❑ Yes ❑ No
Feeding problems? ❑ Yes ❑ No
Vaccinations? ❑ Yes ❑ No

CHILD'S HEALTH HISTORY

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 diagnosis, care plan and the possibility of being accepted for care.

❑ Allergies
❑ Asthma
❑ Attention problems
❑ Bed wetting
❑ Breathing problems
❑ Colic
❑ Constipation
❑ Digestive problems
❑ Ear problems
❑ Frequent colds
❑ Headaches
❑ Hyperactivity
❑ Irritability
❑ Skin problems
❑ Sleeping disorders
❑ Tubes in the ears
❑ Vision problems
❑ Other _____

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).

_____

CHILD'S CURRENT HEALTH STATUS

Has your child ever:	**No**	**Yes**	**If Yes, please explain:**
…taken antibiotics?	❑	❑	_____
…been hospitalized?	❑	❑	_____
…had a severe fall?	❑	❑	_____
…been in a car accident?	❑	❑	_____
Is your child:			
…accident prone?	❑	❑	_____
…had surgeries? Please Explain…			_____
…taking any medication(s)?	❑	❑	_____
having difficulty interacting with others?	❑	❑	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? _____

_____

What changes (if any) in your child's health or behavior would you like accomplished?

_____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:	Yes	No
• Doctors of Chiropractic work with the nervous system?	❑	❑
• The nervous system controls all bodily functions and systems?	❑	❑
• Chiropractic is the largest natural healing profession in the world?	❑	❑

AUTHORIZATIONS

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 doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment.
I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

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

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.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 physicians certifications.

I have read and understand your Notice of Privacy Practices. Amore 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 (Print):_____
Relationship to Patient:_____
Signature:_____Date:_____

AUTHORIZATION FOR CARE OF A MINOR
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 that 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.

Name of parent or guardian: _____Date: _____