6769 Courtland Dr NE Suite 100 – Rockford, MI 49319 P: 616-863-9482 F: 616-863-9486

Confidential Patient Health Record Date: _____ I.D. # _____

PERSONAL HISTORY

Name_____ City: _____

Address: _____ State: _____ Zip: _____

Birth Date: _____ Age: ____ Sex: ☐ M ☐ F Social Security Number:_____

Parent/Guardian Name: _____

Parent/Guardian Home Phone: _____ Cell Phone:_____

Parent/Guardian Email: _____

Whom may we thank for referring you to us?:_____

Name Of Emergency Contact:_____ Relationship:_____ Phone Number:_____

CURRENT HEALTH CONDITION

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

What health challenge(s) is your child here for? _____

What do you feel is the cause of your child's problem?_____

When did you first notice this sign of body dysfunction? ____ / ____ / ____ Please Explain:_____

_____

Are they in pain? ☐ Yes ☐ No Rate his/her pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did his/her pain/injury occur during: ☐ Routine Activities ☐ Sports/Play ☐ Auto Accident ☐ Other _____

Has he/she seen anyone else for this condition? ☐ Yes ☐ No Who?_____

Type of Treatment: _____ Results: _____

Is their condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is their condition interfering with: ☐ School ☐ Sleep ☐ Daily routine? If so, how?_____

HEALTH HISTORY

Is your child a: ☐ Birth child ☐ Adopted child **If your child was adopted please answer all information to the best of your ability*

Was this delivery: ☐ Vaginal Delivery ☐ C-Section
How long was labor and delivery?_____
Were forceps or vacuum extraction used? _____

Was/is your child breastfed? ☐ Yes ☐ No If so, for how long? _____
At what age did your child crawl? How long did they crawl for? _____
Did/does your child like "tummy time?" ☐ Yes ☐ No
Did/do you choose to vaccinate your kids? ☐ Yes ☐ No

HEALTH HISTORY CONT'D

Please Check and Describe:

Major Surgery/Operations/Hospitalizations: ☐ Tubes in Ears ☐ Broken Bones ☐ Bone Fusions ☐ Back surgery ☐ Other

Describe: _____

_____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____

Please check any & all of the following health challenges your child has suffered and/or continues to suffer from:

☐ Allergies	☐ Irregular Sleep Patterns	☐ Mood Swings	☐ Congenital Heart Defect
☐ Ear Infections	☐ Anxiety	☐ Infected/Sore throat	☐ Laryngitis
☐ Tonsillitis	☐ Asthma	☐ Reflux/Spitting up	☐ Poor Appetite
☐ Neck Pain	☐ Upper Respiratory Infections	☐ Frequent Cold/Congestion	☐ ADD/ADHD
☐ Psychiatric Problems	☐ Night Terrors	☐ Bed Wetting	☐ Headaches
☐ Ulcers/Colitis	☐ Fainting/Seizures/Epilepsy	☐ Sinus Problems	☐ Chronic Diaper Rash
☐ Colic	☐ Difficulty Breathing	☐ Diabetes	☐ Bruising
☐ Poor Digestion (constipation/diarrhea)		☐ Eczema/psoriasis/Other skin rashes	

Is your child *currently* taking any prescription medication(s)? ☐ Yes ☐ No

If so, please list those medication(s) here: _____

Has your child taken any prescription medication(s) in the *past?* ☐ Yes ☐ No

If so, please list those medication(s) here: _____

Does your child take any supplements? ☐ Yes ☐ No

If so, please list those supplements here: _____

Does your child exercise regularly? ☐ Yes ☐ No

Please list anything that your child may be allergic to: _____

Dr.'s Notes

_____

_____

_____

_____

_____

ChiroHealth HIPAA Form

Patient's Name: _____

Patient's SSN: _____ Date of Birth: _____

SPECIFIC AUTHORIZATIONS-CHECK ALL THAT APPLY

( ) I give permission to **ChiroHealth Rockford** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards and any information about treatment(s). If **ChiroHealth Rockford** contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

( ) I give **ChiroHealth Rockford** permission to use and disclose my protected health information to the entities of my choosing, some of which may or may not be listed below.

APPROVED ENTITIES FOR PERSONAL HEALTH INFORMATION

Name: _____ Relationship: _____

Approved type(s) of information: ( ) Diagnosis ( ) Treatments ( ) Appointments ( ) Financial Records

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_____
Signature of Patient or Personal Representative

_____
Date

RIGHT TO REVOKE HIPAA AUTHORIZATION

- You have the right to revoke this authorization, in writing, at any time. Please send such requests to:
  ChiroHealth Rockford
  Attn: Office Manager
  6769 Courtland Dr. Ste. 100
  Rockford, MI 49341
  Phone: 616-863-9482
  Fax: 616-863-9486
- You may refuse to sign this HIPAA authorization. If you refuse to sign this authorization it will not affect your ability to obtain treatments.
- Upon request, a copy of this authorization will be provided to you.
- I have read / received the information about the Health Insurance Portability and Accountability Act. **Initials:** _____