PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____

Birth date _____

SS#_____

Age _____ Gender _____ Weight_____

ABOUT THE PARENT

Name_____

Employer_____

Work address _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

Driver's License # _____

E-mail address_____

Payment method ❑ Cash ❑ Check ❑ Credit card

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).

_____

REASON FOR THIS VISIT

Describe the purpose of 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 ❑ 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 _____

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?	❑	❑
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	❑	❑

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

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?
❑ Did Dr. pull or twist baby? ❑ Premature delivery

Please explain _____

Did you nurse the 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 _____

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever: …taken antibiotics?	❑	❑	_____
…been hospitalized?	❑	❑	_____
…had a severe fall?	❑	❑	_____
…been in a car accident?	❑	❑	_____
Is your child …accident prone?	❑	❑	_____
Had Surgery? Please Explain…			_____
…currently 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?

GOALS FOR MY CHILDS CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ **Relief care** – Symptomatic relief of pain or discomfort

❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition.

Parent or guardians signature:_____Date:_____

Childs name:_____

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 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:_____

Paci Chiropractic, Inc.
200 Northern Ave.
Hagerstown Md. 21742
301-733-4445

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Pulse:_____

PACI CHIROPRACTIC, Inc.
200 Northern Avenue
Hagerstown, MD 21742

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____