

# 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:	
<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	

## 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:	
<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):	

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

**Bender Family Chiropractic**  
33580 Harper Ave.  
Clinton Twp, MI 48035

## 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

☐ FORCEPS/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

VACCINATIONS?

☐ 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:

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Section 8: Notice of Privacy Practices Acknowledgement**  
**Initial Uses Authorization Form**  
**Bender Chiropractic Health and Vitality Center**

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Bender Chiropractic Health and Vitality Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. William L. Bender

Bender Chiropractic Health and Vitality Center also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. \_\_\_\_\_ (please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. William L. Bender

You can reach the Privacy Official at: Bender Chiropractic Health and Vitality Center, 33580 Harper Avenue, Clinton Township, MI, 1-586-738-6833

Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: \_\_\_\_\_ (you may receive PHI through email)

Print Patient Name: \_\_\_\_\_

Signature Patient/Personal Representative: \_\_\_\_\_

Relationship of Personal Representative: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

=====

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices  
Other:

\_\_\_\_\_

Staff Signature: \_\_\_\_\_ date: \_\_\_\_\_