



It is our pleasure to be of service to you. To help us serve you better please fill out our confidential Patient Health Record completely and accurately.

Studer Chiropractic is dedicated to removing nerve interference by hand to restore and maintain optimum health.

Through education we promote a lifetime of health, strength, and vitality.

We envision chiropractic care for every man, woman and child to build a healthier community and world.

## **CHILD HISTORY (Ages 0-4)**

## ABOUT THE PATIENT

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Name of Parents/Guardians \_\_\_\_\_  
Sibling's names and ages \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Would you like us to email you our free newsletter?  Yes  No

## REASON FOR THIS VISIT

Describe the purpose of this visit \_\_\_\_\_  
\_\_\_\_\_

When and how did this health challenge begin? \_\_\_\_\_  
\_\_\_\_\_

Since the problem began, is it:

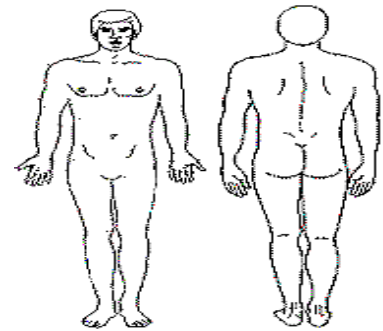
Getting Better  Getting Worse  About the Same

Using the diagram to the right please indicate with an X where  
your child notices discomfort or problems occurring →

What is the pattern of this problem?

Constant  Intermittent  Occasional  Cyclic

What have you tried to improve this condition?  
\_\_\_\_\_



Have you seen other professionals for this condition?  Yes  No

Dr.'s Name (s) \_\_\_\_\_

Type of Treatment \_\_\_\_\_

What are your objectives in consulting us? \_\_\_\_\_

## HEALTH HISTORY

Who referred you to this office? \_\_\_\_\_

Has your child been adjusted by a Chiropractor before?  Yes  No

Previous Chiropractor's Name \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Reason for those visits? \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Frequency of Visits: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Number of doses of Antibiotics your child has taken:

During past six months \_\_\_\_\_ Total during lifetime \_\_\_\_\_

Number of doses of other prescription medications your child has taken:

During past six months \_\_\_\_\_ Total during lifetime: \_\_\_\_\_

Please list \_\_\_\_\_

Please list any OTC drugs taken in past six months \_\_\_\_\_

Has your child ever been hospitalized, had any surgeries or major illnesses?

No  Yes, please explain \_\_\_\_\_

Vaccination History \_\_\_\_\_ Any reactions? \_\_\_\_\_

Have you withheld any Vaccines?  No  Yes Why? \_\_\_\_\_

**The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.**  
 This interference is most commonly the result of **vertebral subluxations**. Subluxations may be caused by physical, chemical or emotional stress.  
 The practice of chiropractic is based on locating and reducing nerve system interference caused by the **vertebral subluxations**.

Please check any of the following conditions that your 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 and care plan.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Colic                          | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Scoliosis     | <input type="checkbox"/> Recurring Fevers   |
| <input type="checkbox"/> Ear Infections                 | <input type="checkbox"/> Bed Wetting       | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Chronic Colds                  | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Back Pain     | <input type="checkbox"/> Acid Reflux        |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Temper Tantrums   | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Poor Nutrition     |
| <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Car Accident  | <input type="checkbox"/> Limited Exercise   |
| <input type="checkbox"/> Sinus Problems                 | <input type="checkbox"/> Anxiety/ADHD      | <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Low Energy         |
| <input type="checkbox"/> Other Health Conditions: _____ |  |  |   |

<b>Does anyone in your household:</b>	<b>No</b>	<b>Yes (please explain)</b>
Smoke?	<input type="checkbox"/>	<input type="checkbox"/> ___ # packs/day
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/> ___ # drinks/week
Drink coffee/soda?	<input type="checkbox"/>	<input type="checkbox"/> ___ # cups/day
Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/> _____
Take any supplements?	<input type="checkbox"/>	<input type="checkbox"/> _____

**Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions.**

**Prenatal history:**

Name of Obstetrician/Midwife \_\_\_\_\_

Location of Birth  Hospital \_\_\_\_\_  Birthing Center \_\_\_\_\_  Home

Complications during pregnancy?  No  Yes, Please explain \_\_\_\_\_

Ultrasounds during pregnancy?  No  Yes, How Many? \_\_\_\_\_

Medications, tobacco, alcohol drugs during pregnancy?  No  Yes, Please Explain \_\_\_\_\_

Labor chemically induced?  No  Yes, why? \_\_\_\_\_

Complications during delivery?  No  Yes, Please explain \_\_\_\_\_

Birth Interventions?  Forceps,  Vacuum Extraction,  
 Cesarian Section:  Emergency,  Planned

**Feeding History:**

Any difficulties eating or nursing?  No  Yes

Breast Fed?  No  Yes, How long? \_\_\_\_\_

Formula Fed?  No  Yes, Type? How long? \_\_\_\_\_

Food Allergies or Intolerances \_\_\_\_\_

### Developmental History

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

- |                                 |                   |
|---------------------------------|-------------------|
| _____ Respond to Sound          | _____ Cross Crawl |
| _____ Respond to Visual Stimuli | _____ Stand Alone |
| _____ Hold Head Up              | _____ Walk Alone  |
| _____ Sit Up                    |                   |

### Traumas

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.).

Was this the case with your child?  No  Yes

Has your child been involved in any high impact or contact sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)?

No  Yes, List \_\_\_\_\_

Has your child been involved in a car accident?  No  Yes, List \_\_\_\_\_

Please list any additional traumas not mentioned above: \_\_\_\_\_

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### WHICH BEST DESCRIBES YOUR REASON FOR CONSULTING OUR OFFICE?

Please check the one choice that most closely describes your current goals for your child's health and wellbeing.

- I am only concerned about relief of a particular symptom.
- I am only concerned about relief of a particular symptom, and preventing its return.
- I want optimum health and wellbeing on every level available to me.

**We are here to serve you, you are encouraged to ask questions.  
Your participation in care is vital and will help determine your results**

### AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Studer Chiropractic P.C. and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office and that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records for a fee at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

Guardian Signature

Date