SMITH family CHIROPRACTIC
Realigning Health and Wellness

Youth Health Questionnaire

Today's Date: _____ Child's Full Name: _____

Birthdate: _____ Sex: _____ Age: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Best Contact Number: _____ please circle: cell work home

Parent/Guardian Name(s): _____

_____

INDICATE YOUR CHILD'S PAST OR PRESENT CONDITIONS: Please mark "P" for past or "N" for Now (present) or "B" for Both

_____ Fractured Bones	_____ Trouble Concentrating	____Heart Problems
_____ Auto Accidents (circle)	_____ Loss of Memory	____Stroke
<1 yr ago 1-5 yrs ago >5yrs ago	_____ Learning Disability	____High or low blood pressure
_____ Other Accidents or Falls	_____ Mistake Sidedness (R from L)	____Varicose Veins
_____ Knocked Unconscious	_____ Stutter	____Liver Trouble
_____ Back Curvature	_____ Dyslexia	____Gall Bladder trouble
_____ Mental or Emotional Disorders	_____ Mood Changes	____Digestive problems
_____ Arthritis	_____ Lose Temper Easily	____Excessive Gas
_____ Diabetes	_____ Headache	____Belching or bloating after meals
_____ Swollen or Painful Joints	_____ Neck Pain or Stiff R or L	____Heartburn
_____ Convulsions / Epilepsy	_____Jaw pain or click (TMJ) R or L	____Ulcers
_____ Skin Problems	_____ Head seems too heavy	____Diarrhea/constipation
_____ Itching	_____ Head and Shoulders feel tired	____Colon Trouble
_____ Bruise Easily	____Shoulder pain R or L	____Hemorrhoids
_____ Cancer	____Upper back pain or stiffness R or L	____Prostate problems
_____ Frequent Colds/Flus	____Mid back pain or stiffness R or L	____Kidney trouble
_____ Nervous	____Lower back pain or stiffness R or L	____Kidney stones
_____ Tension	____Pain with cough	____Frequent urination
_____ Irritable	____ Sneeze or strain at stools	____Discharge
_____ Anemia	____Hip pain R or L	____Bedwetting
_____ Excess Sweating	____Foot trouble R or L	____Ear infections
_____ Tremors	____Fainting	____Hepatitis
_____ Light Bothers Eyes	____Loss of balance	____Venereal Disease
_____ Allergies	____Blurred or double vision R or L	____AIDS/HIV
_____ Sinus Problems	____Wheezing	____Dizziness
_____ Light Headed Upon Rising	____Difficult breathing	____Ringing in ears R or L
_____Under Stress	____Lung problems	____Hearing Loss R or L
_____ Craves Sweets or Salts	____Asthma	_____ Eating Disorders
_____ Diabetes	____Chest pain	_____ Trouble Sleeping
_____ Numbness, tingling, or pain in arms, hands, fingers, R or L	_____ Numbness, tingling, or pain in buttocks, thighs, legs, feet, toes, R or L	_____ Other

PLEASE FILL IN THE APPROPRIATE SPACES (all information you give is confidential):

Major Complaint: _____

_____

How long has this condition been present? _____ Date Began: _____

Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic exam?

_____

Difficult, long, and/or doctor assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup, or other device? YES ___ NO ___ If yes, describe: _____

How long was the actual labor time and delivery time? _____

Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? YES ___ NO ___ If yes, describe: _____

Has your child has any surgeries? YES ___ NO ___ If yes, describe: _____

Please list any drugs or supplements your child is currently taking (prescription and non-prescription):

_____

Name other doctors your child has seen for this condition: What was done, and for how long?

_____

_____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our Only Practice Objective is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature of Patient/or Guardian:_____Date: ____/____/____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of

_____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of Patient/or Guardian:_____ **Date:** ____/____/____

HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES SMITH FAMILY CHIROPRACTIC AND ASSOCIATES TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Smith Family Chiropractic and Associates to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Smith Family Chiropractic and Associates to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following you are giving Smith Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian:_____ **Date:** ____/____/____

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures; I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent.
* The right to object to the use of my health care information for directory purpose.
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian:_____ **Date:** ____/____/____

By your own request we are able to share personal health information. Are there any family members or individuals you would like to authorize to view your personal and private health information (Including appointment times, health information from this clinic or others that we have received, etc.?)

I would like to share my personal health file and appointment times with:
(if none write n/a)

_____

_____

Signature of Patient/or Guardian:_____ **Date:** ____/____/____