Pediatric History Form

Child's Name:_____ Nickname:_____

SSN: _____ Birthday: _____ Age: _____ ☐ Male ☐ Female

Name of Parents/Guardians: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Work Phone: _____ Email: _____

How did you first hear of Corrective Chiropractic?

☐ Parent is a patient ☐ TV ☐ Newspaper ☐ Billboard ☐ Friend ☐ Other: _____

Who can we thank for referring you to us: _____

Purpose for Contacting Us? _____

Other doctors seen for this condition? ☐ Yes ☐ No If yes, please list Doctors and treatments:

1. _____
2. _____
3. _____

Health History:

Check any of the following conditions your child has suffered from during the last 6 months:

☐ ear infections	☐ seizures	☐ growing pains
☐ asthma/allergies	☐ ADHD	☐ neck pain
☐ colic	☐ car accident	☐ back pain
☐ scoliosis	☐ chronic colds	☐ sleeplessness
☐ digestive problems	☐ recurring fevers	☐ eczema / skin problems
☐ bed wetting	☐ headaches	☐ other: _____

Has your child ever been hospitalized? ☐ yes ☐ no If yes, why? _____

Has your child had any significant injuries? _____

Is your child on any medications? _____

Has your child taken any antibiotics? ☐ no ☐ yes;

If yes, how many doses in the last 6 mo? _____ Total during his/her lifetime: _____

Has your child been vaccinated? ☐ no ☐ yes; When: _____

Any childhood diseases?

☐ chicken pox	☐ whooping cough	☐ RSV
☐ rubella	☐ mumps	☐ other: _____
☐ measles	☐ pertusses	

Name of Pediatrician: _____

Prenatal History:

Mom's Health during pregnancy: _____

Complications during pregnancy: ☐ no ☐ yes ; please list: _____

Medications during delivery: Induction ☐ yes ☐ No Epidural ☐ yes ☐ no Other: _____

Birth intervention: ☐ forceps ☐ vacuum extraction ☐ caesarian – emergency / planned?

Complications during delivery: ☐ no ☐ yes ; Please list: _____

DELIVERY: ☐ < 36 WEEKS ☐ 37 – 42 WEEKS ☐ > 42 WEEKS

BIRTH WEIGHT: _____ LENGTH _____

FEEDING HISTORY:

BREAST FED: ☐ YES ☐ NO ; HOW LONG? _____

FORMULA FED: ☐ YES ☐ NO ; HOW LONG? _____

INTRODUCED TO SOLIDS AT: _____MONTHS; COW'S MILK AT _____ MONTHS

FOOD / JUICE ALLERGIES OR INTOLERANCES ☐ NO ☐ YES; PLEASE LIST: _____

DAILY ACTIVITES/SPORTS

IS YOUR CHILD INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS? (I.E. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC)

PLEASE LIST ANY INJURIES AS A RESULT OF THEIR ACTIVITIES: _____

_____

REGARDING SYMPTOMS:

IS IT RELATED TO AN AUTOMOBILE ACCIDENT? ☐ NO ☐ YES

WHEN DID THE SYMPTOMS FIRST START? _____

HOW FREQUENT IS THE PAIN? _____

HOW DID THIS HAPPEN? _____

DESCRIBE THE PAIN: _____

WHAT MAKES IT WORSE? _____

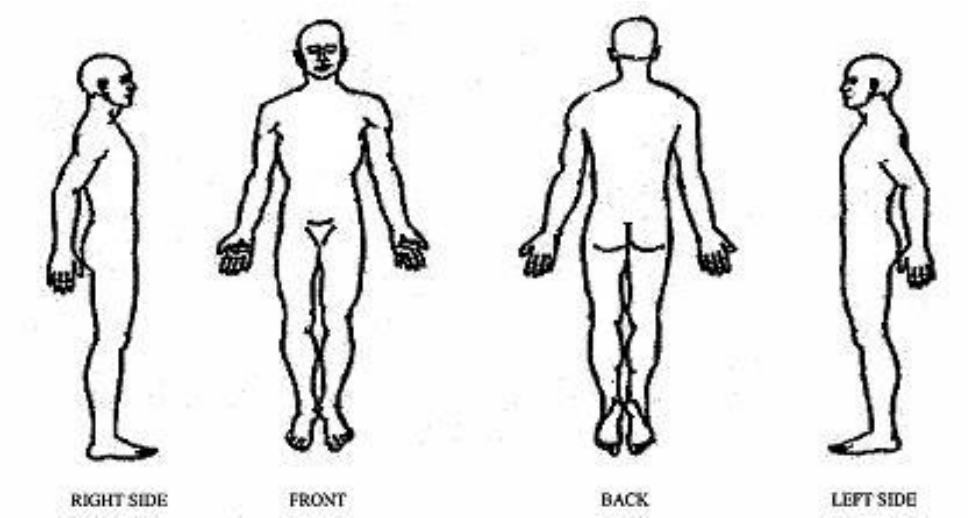
WHAT MAKES IT BETTER? _____

DOES IT RADIATE TO ANY OTHER PARTS OF YOUR BODY? _____

HAS THIS CHANGED ACTIVITIES AT HOME? _____

Please mark the areas of all of your complaints on the diagrams to the right.

N = numbness
T = tingling
P = pain
W = weakness



PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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 and rehabilitation facility we have one main objective: 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 objective, thus preventing any confusion or disappointment.

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.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- Health/Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
    - In-Network Policies: We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement. Co-pays will be paid by patient, reimbursement checks will be payable to us.
    - Out-of-Network Policies: We will give you receipts to file with your insurance company. Patient will pay cash prices up front. Insurance company will reimburse the patient.
    - If your policy has a deductible feature, it is due at the time of service.
    - In accordance with Medicare Guidelines, Maintenance Care is not a covered benefit and therefore will not be billed to your insurance company.
    - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISKS OCCURING

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED

- *Over-the-counter analgesics*. Temporarily relieves pain but does not address the cause of the symptoms. Masking the pain means you may not feel additional damage. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, injections, and analgesics. Temporarily relieve pain but do not address the cause of the symptoms. Masking the pain means you may not feel additional damage. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

CONSENT

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

ADDITIONAL PRIVACY PRACTICES

- We may call you by name in the reception area when the doctor is ready to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whomever answers or on your answering machine.
- We may include a photo of you on our referral wall.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Corrective Chiropractic and Wellness

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Corrective Chiropractic and Wellness.

I understand that the Notice describes the uses and disclosures of my protected health information by Corrective Chiropractic and Wellness and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*