Patient Information-Pediatric

Today's Date:_____

Patient Information

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Date of Birth:_____ Age:_____ Male/Female Phone #:_____

Address:_____ City:_____ State_____ Zip_____

Emergency Contact:_____ Relation:_____ Phone #:_____

Responsible Party (Guardian)

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Date of Birth:_____ Relationship to Patient:_____

Address:_____ City:_____ State_____ Zip_____

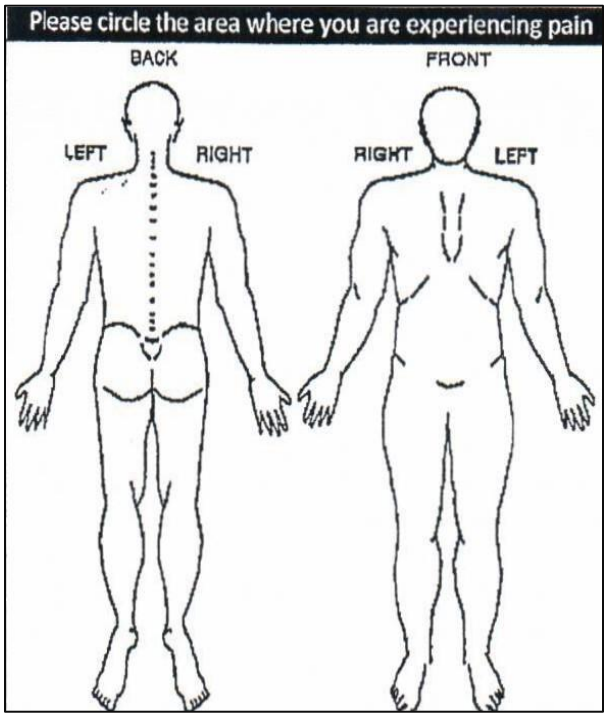
Cell Phone #:_____ Email Address:_____

Has your child been seen by a Chiropractor before?_____ If yes, when?_____

Whom may we thank for referring you to our office?:

- ☐ Google
- ☐ Facebook
- ☐ Yellow Pages
- ☐ Referral _____

Major Complaint Information



For what health challenge(s) is your child here for?

Chief Complaint—Briefly describe the symptoms: Is this due to an accident? Yes/ No

_____

_____

_____

Secondary Complaint—Briefly describe the symptoms: Is this due to an accident? Yes/ No

_____

_____

_____

What do you feel is the cause of your child's problem?

_____

_____

Over→

Check the activities below during which your child may experience difficulty or pain:

- ☐ Lying on side
- ☐ Turning over in bed
- ☐ Lying flat on stomach
- ☐ Getting in/out of car
- ☐ Dressing self
- ☐ Pushing
- ☐ Pulling
- ☐ Reaching
- ☐ Kneeling
- ☐ Stooping
- ☐ Sitting
- ☐ Bending Forward
- ☐ Bending Backward
- ☐ Walking
- ☐ Running
- ☐ Standing for long periods
- ☐ Sneezing
- ☐ Coughing
- ☐ Other:_____

Please list any and all other concerns regarding your child's health whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____

_____

- ☐ Allergies
- ☐ Ear Infection
- ☐ Colic
- ☐ Poor Digestion
- ☐ Constipation/Diarrhea
- ☐ Irregular Sleep Patterns
- ☐ Anxiety
- ☐ Frequent Colds/Flu
- ☐ Congestion
- ☐ Infected/Sore Throat
- ☐ Reflux/Spitting up
- ☐ Thrush mouth/Chronic Diaper Rash
- ☐ Night Terrors
- ☐ Mood Swings
- ☐ Upper Respiratory Infection
- ☐ Tonsillitis
- ☐ U-Tract Infections
- ☐ Nervousness
- ☐ Eczema/Psoriasis/ Other skin rashes
- ☐ Bed wetting
- ☐ Bruising
- ☐ Asthma
- ☐ Laryngitis
- ☐ Poor appetite
- ☐ ADD/ADHD
- ☐ Headache
- ☐ Upset stomach

List any surgeries and dates: _____

List any illnesses and dates: _____

Height:_____ Weight:_____

Family History

	Self Age:	**Father Age:**	**Mother Age:**	**Brother(s) Age:**	**Sister(s) Age:**	**Grandpa Age:**	**Grandma Age:**
Arthritis							
Back/Neck Pain							
Bursitis							
Cancer							
Diabetes							
Disc Problems							
Emphysema							
Epilepsy							
Heart Troubles							
High Blood Pressure							
Kidney Trouble							
Migraines							
Nervousness							
Scoliosis							
Sinus Troubles							
Sleeping Troubles							
Stomach Troubles							
Ehlers Danlos							
Other							

Informed Consent for Chiropractic Treatment

PATIENT NAME: _____ **DATE:** _____

Please read this entire document before signing it. It is important that you understand the information contained in this document. Please ask any questions you may have prior to signing it if anything is unclear.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment you consent to the following procedures (one or more of the following procedures may be used): manipulative therapy, ice or heat, soft tissue therapy, range of motion and muscle strength testing, ultrasound, orthopedic testing, palpation, vital signs, and basic neurological testing. A referral will be made by the doctor for further diagnostic studies (x-rays, blood work, etc) if needed.

The nature of the chiropractic adjustment:

The primary treatment used by doctors of chiropractic is manipulative therapy. The doctor may use their hands or a mechanical instrument upon your body in such a way as to move your joints (this is the adjustment). This may or may not cause an audible "pop" or "click" much like you have experienced when "cracking" your knuckles. You may feel a sense of movement.

The risk of the chiropractic adjustment:

As with any procedure, there are certain complications that may arise during the adjustment or other therapies used. These complications include but are not limited to: stiffness, soreness, muscle strain, joint sprains, and fracture (generally resulting from underlying weakness of the bone which we will screen for in the history and exam). Some types of manipulation of the neck have been associated with injuries to the arteries in the neck which could lead to further complications, including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The doctor will make every effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

Availability and nature of other treatment options:

Other treatment options for your condition may include: over-the-counter medications, rest, medical care, prescription drugs, hospitalization, and surgery.

Risks of remaining untreated:

Remaining untreated may allow the formation of adhesions (scar tissue) and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. *I have read and understand the above risks and hereby give my consent to treatment.*

Patient signature (Guardian):_____**Date:**_____

HIPAA Agreement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Payment and Insurance Agreement

Patient Responsibilities: Payment is due at time of service for all patients who have not met their deductible or do not have insurance. You must provide us with a current insurance card and billing information at the initial visit. If your insurance policy has changed, it is your responsibility to give Explore Wellness PLLC the updated information. Your insurance policy is a contract between you and the insurance company. Explore Wellness PLLC will bill your insurance as a courtesy and make every effort to ensure claims are promptly and correctly submitted. You are responsible for all unpaid balances.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, co-pay or any service(s) that is not covered by my insurance carrier at the time the service.

Patient Name (Print):_____ **Date:**_____

Patient Signature:_____ **Date:**_____

Guardian Signature:_____ **Date:**_____