PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____Mother's Mobile _____DOB____/____/____

Fathers name: _____Father's Mobile_____DOB ____/____/____

Pediatrician/Family MD _____City & State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____
☐ Other *(please explain):*

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ____Wellness Check-up ____Injury or Accident ____Other

Please explain: _____

_____

*If your child is experiencing **Pain/Discomfort please identify where and for how long***

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1. **When did the** Problem first begin? Date ___/___/_____ ____Unknown ____Gradual ____Sudden
2. **Ever had** this problem **before**? No_____Yes_____ If yes, when? _____
3. Any **bowel or bladder** problems since this problem began? If yes,

   *(*Describe*)*:_____
4. Have you seen any **other doctors** for this problem? No Yes If yes who? _____
5. How long ago? _____Days _____ Weeks _____ Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW**: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off
8. Please list any **medication taken** for this problem: _____
9. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain

   _____

   _____
10. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

    _____

HAS YOUR CHILD EVER SUFFERED FROM:

□ Headaches	□ Orthopedic Problems	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Aches	□Ruptures/Hernia
□ Seizures/Convulsions	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Chronic Earaches	□ Backaches	□ Diarrhea	□ Allergies to_____
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Asthma
□ Scoliosis	□ Anemia	□ Colds/Flu	□ Walking Trouble
□ Bed Wetting	□ Colic	□ Broken Bones	□ Sleeping Problems
□ Fall in baby walker	□ Fall down stairs	□ Fall from playset	□ Fall from crib
□ Fall off bicycle	□ Fall off swing	□ Fall off bed or couch	□ Fall off skateboard/skates
□ Fall from high chair	□ Fall off slide	□ Fall from changing table	

□ Other:

_____

_____

_____

I understand that I am directly and fully responsible to Essential Health Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor Signature Date

Essential Health Chiropractic
Notice of Privacy Practice – HIPPA

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To request mailings to an address different than residence
2. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

I have received a copy of Essential Health Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

_____ _____

Patient's Name DOB

_____ _____

Parent/ Legal Guardian Signature Date

PRACTICE TERMS AND OBJECTIVES

1. **Our Practice Objective:** is to reduce or eliminate a major interference to the expression of your body's inborn ability to heal. We offer a patient-centered perspective incorporating both therapeutic and preventative approaches. We place particular attention to maintaining optimum body structure and nerve function as well as promoting improved health through evaluation of our patient's health behaviors and conditions.

2. **Health:** The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. Health is the ability to adapt to physical, chemical and emotional stress. It is a state of optimal well being, not merely the absence of disease or symptoms.

3. **Subluxation:** A misalignment or alteration of one or more of the 24 vertebra in your spinal column or other joints of the body that can affect your brain and nervous system communication as well as body and organ system function. Subluxations can result in a lessening of your body's inborn (innate) ability to heal and express its maximum health potential.

4. **Adjustment:** A chiropractic adjustment is the specific application of forces to facilitate the body's correction of a subluxation. Our chiropractic method of correction is by specific adjustment of the spine or other joints of the body. However, we may use other procedures to help your body hold the adjustment.

5. **We Do Not:** Prescribe medications, perform surgery or any other medical procedure related to the treatment of disease. If you wish to decrease or stop prescription medications, you should discuss this with your medical doctor. If during the course of a chiropractic examination or visit, we encounter unusual findings, we will let you know of them. If we find that your case will not respond to chiropractic care and/or if you desire to investigate for further advice, diagnosis or treatment for those findings, we will offer cooperative patient management, referral to, communication and collaboration with other health care providers to ultimately benefit you as a patient.

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.

_____	_____	_____
Print Name	Parent/Legal Guardian Signature	Date