PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better heath for your family.

Patient Name: ____

Address: ____ City: ________________________________

State: ______________ Zip: __________ Home Phone: ____

Birth Date: _______ / _______ / _______

Sex (circle one): M F

Weight: __________ Height: __________ Referred By: ______________________________________

Names of Parents / Guardians: ____

Purpose for Contacting Us? ____

Other Doctors Seen for this Condition: _______ N _______ Y Doctors' Names and Prior Treatments: ____________________

____

Other Health Problems? ____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

___ Ear Infections ___ Scoliosis ___ Seizures ___ Chronic Colds ___ Headaches
___ Asthma / Allergies ___ Digestive Problems ___ ADHD ___ Recurring Fevers ___ Growing / Back Pains
___ Colic ___ Bed Wetting ___ Car Accident ___ Temper Tantrums ___ Other _______________

Family History: ____

Previous Chiropractor: ____

Date of Last Visit: _______ / _______ / _______ Reason: ____

Name of Pediatrician: ____

Date of Last Visit: _______ / _______ / _______ Reason: ____

Are You Satisfied with the Care Your Child has Received There? _______ N _______Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____________________________

Vaccination History: ____

Prenatal History:

Name of Obstetrician / Midwife: ____

Complications During Pregnancy? _____N _____Y , List: ____

Ultrasounds During Pregnancy? _____ N _____Y , Number: ________

Medications During Pregnancy / Delivery? _____ N _____Y , List: ___________________________________

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _______ Hospital _______ Birthing Center _______ Home

Birth Intervention: _______ Forceps _______ Vacuum Extraction

_______ Caesarian Section , Emergency or Planned ?

Complications During Delivery? _______ N _______ Y , List: ____

Genetic Disorders or Disabilities: _______ N _______ Y , List: ____

Birth Weight: __________ Birth Length: __________ APGAR Scores: _______ , _______

Feeding History:

Breast Fed: _______ N _______ Y , How Long: _______

Formula Fed: _______ N _______ Y , How Long: _______

Introduced to Solids at: _______ Months , Cows' Milk at _______ Months

Food / Juice Allergies or Intolerances: _______ N _______Y , List: ____

____

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

_______ Respond to Visual Stimuli

_______ Hold Head Up

_______ Sit Up

_______ Cross Crawl

_______ Stand Alone

_______ Walk Alone

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, ect.). Was this the case with your child? _______N _______Y

Is / has your child been involved in any high impact or contact type sport (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Marital Arts, ect.) ? _______ N _______Y , List: ____

____

Has your child ever been involved in a Car Accident ? _______ N _______ Y , List: ______________________________

Has your child been seen on an Emergency Basis ? _______ N _______ Y , List: ______________________________

Other Traumas Not Described Above ? _______ N _______ Y , List: ______________________________________

Prior Surgery: _______ N _______ Y , List: ____

Menarche: _______ N _______ Y , Age: _______

Childhood Diseases:

Chicken Pox	N / Y, Age _______	Mumps	N / Y, Age _______
Rubella	N / Y, Age _______	Whooping Cough	N / Y, Age _______
Rubeola	N / Y, Age _______	Other	N / Y, Age _______

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.
AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office 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.

Name of Insurance Company: ____ Policy #: ______________________________

Signed: _____________________________________ Date: _____ / _____ / _____

Financial Information

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

****The cash fee for a new patient is $150.00, which includes the first consult, a chiropractic exam, a report of findings, and the first adjustment****

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the "Insurance Permission" section below.

Signature ____ Today's Date _______________

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

"I authorize Community Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."

"I authorize payment be made directly to Community Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature: ____ Date ______________________

Also, if you are not the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name: __________________________ Subscriber's date of birth: ________________

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Community Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience at Community Chiropractic.
- We often take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Community Chiropractic.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

We at Community Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Community Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

______________________________	______________
Patient name printed	Date
______________________________	______________
Patient Signature	CC representative

Terms and Consent to Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

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.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, ______________________________ have read and fully understand the above. (print name)

Outcomes and options relative to care have been discussed and noted. 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)

______________________ (date)

Name: ____ Date:_____________
Last First

CREDIT CARD AUTHORIZATION

I, ___________________________, give authorization for Community Chiropractic to charge my credit card for any and all services rendered to me. I acknowledge that I am legally responsible for any and all charges and I authorize my credit card to be charged the total of any back balance if I decide to discontinue my care.

( ) Master Card ( ) Visa ( ) FSA/HSA

Credit Card Number:____
Expiration Date:__________________________Security Code(3 digits):_________
Address of Credit Card:________________________________Zip Code:_________
____
Signature:_____________________________________Date:__________________

Our purpose is to educate and adjust families toward optimal health with natural chiropractic care