Pediatric History Form

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 health for your family.

Subluxations or spinal misalignments are a condition of the spine that Chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the result of these subluxations. Often other symptoms are apparent for years before spinal pain is noticed. It is for this reason we ask a wide variety of questions regarding your health.

Patient Name_____Nick Name_____

Birth Date _____ Sex □ M □ F Weight_____ Height_____

Name of Parents / Guardians_____

Address City State Zip _____

Home Phone_____ Parent's Work Phone_____ Cell Phone_____

Number and ages of siblings_____

Email Address_____May we send you office newsletters? □ Yes □ No

How did you hear about our office? _____

CONSULTATION

Reason for seeking chiropractic care: _____

When did the problem begin? _____

Is this problem □ occasional □ frequent□ constant□ intermittent □ other _____
Does the problem radiate? □ No □ Yes If yes, where? _____
What makes it worse? _____
What makes it better? _____
Is the problem worse during a certain time of the day? □ No □ Yes If YES, when? _____
Does this interfere with the child's □sleep □eating □daily routine? Is this becoming worse? □ No □ Yes If yes,

how? _____Other professionals seen for this condition? _____

Results with treatment? _____

Other Health Problems _____

FAMILY HEALTH HISTORY

Previous Chiropractor: _____ Rate your experience (1-10)? _____

Date of last visit & Reason: _____.

Name of Medical Doctor: _____. Rate your experience (1-10)? _____

Date of last visit &Reason: _____.

Are you satisfied with the care your child received there? □ Yes □ No

Number of antibiotics your child has taken: Past 6 months_____ Total during his/her lifetime_____

Circle all drugs your child is taking including prescription and non-prescription drugs,

☐ Tylenol, Advil	☐ Allergy	☐ Asthma	☐ Anti-Depressants
☐ Cold tablets	☐ ADHD	☐ Painkillers	☐ Reflux

Other: _____.

Does your child take any Vitamins or Herbs? □ No □ Yes _____.

PRENATAL HISTORY

Location & type of Birth Attendant: □Home □Birthing Center □Hospital □OBGYN □Midwife
Complications during pregnancy: □ No □ Yes List: _____

Ultrasounds during pregnancy: □ No □ Yes How Many: _____ Birth intervention: □ Forceps □ Vacuum

□ Caesarian: Planned or Emergency Complications during delivery: □ No □ Yes _____

Medications during pregnancy / delivery: □ No □ Yes List: _____

Cigarette or Alcohol during pregnancy: □ No □ Yes Breast Fed: □ No □ Yes How long? _____

Birth weight_____ Birth length_____ Formula fed: □ No □ Yes How long? _____

APGAR scores_____ Solids at _____ months

Cow's milk at _____ months Food/juice allergies or intolerances □ No □ Yes

Anything else that needs to be noted:_____

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? □ No □ Yes

If No, please explain_____

At what age did your child: Respond to sound_____Follow an object_____ Hold up head _____
Vocalize_____ Sit alone_____ Crawl_____Walk_____
Do you consider your child's sleeping pattern normal? □ No □ Yes Number of hours sleeping per night: _____
Quality of sleep: Good Fair Poor

VACCINATION HISTORY

Any complications such as excessive crying, fevers, convulsions, loss of development? _____

_____

CHILDHOOD DISEASES

Chicken Pox □ No □ Yes Age _____ Mumps □ No □ Yes Age _____ Rubella □ No □ Yes Age _____

Whooping cough □ No □ Yes Age _____Other _____ □ No □ Yes Age _____

Has your child ever suffered from: (Check all that apply)

□ Dizziness	□ Fatigue	□ Loss of smell	□ Stomach aches
□ Backaches	□ Digestive	□ Muscle jerking	□ Irritability
□ Heart trouble	□ Sinus	□ Fainting	□ Sore throats
□ Chronic earaches	□ Constipation	□ Walking problems	□ Depression
□ Diabetes	□ Anemia	□ Broken bones	□ Loss of balance
□ Shortness of breath	□ Diarrhea	□ Ruptures / Hernias	□ Bronchitis
□ Colds / Flu	□ Poor Appetite	□ Neck Problems	□ Poor coordination
□ Hypertension	□ Hyperactivity	□ Arm problems	□ Diabetes
□ Arthritis	□ Urinary problems	□ Leg problems	□Muscle Cramps
□ Headaches	□ Behavioral	□ Growing pains	□Acid Reflux
□ Asthma	□ Bed Wetting	□ Joint Problems	□ ADD/ADHD
□ Allergies	□ Convulsions	□ Blood disorders	□ Epilepsy

Which of the above conditions do you expect to be helped with chiropractic care?

_____

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Is this the case with your child? □ No □ Yes

When was your child's most recent fall? _____ What happened?

_____

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of your child's.

Which of the following sports have your child been involved in?

□Football □ Soccer □Cheerleading □ Running

□ Basketball □ Gymnastics □ Martial Arts □ Horseback riding

□ Other: _____.

Has your child ever …. □ Fallen down the stairs □ Slipped/Fell on the ground (or ice) □ had a sports injury.

Had a stress or strain while at school □ Broken a bone □ if so, which one? _____.

Has your child ever been involved in a car accident? □ No □ Yes, Was there impact? □ No □ Yes, Were there injuries □ No □ Yes? (Dates/any treatment) _____

_____

Has your child ever been seen on an emergency basis? □ No □ Yes (please list all) _____

_____

Other traumas not described above? □ No □ Yes _____

Prior surgery: □ No □ Yes Type and Date: _____ Menses: □ No □ Yes Age: _____

REGARDING PAYMENT AND AUTHORIZATION TO TREAT A MINOR:

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore I understand that the Doctor's office will prepare a Superbill to assist me in making a collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary, this includes radiographic examination at the doctor's discretion. It is understood and agreed the amount paid to the Doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The parent also agrees that he/she is responsible for all bills incurred at this office for their child and agrees to pay minimal charges for all services and products rendered and to agree to arbitration for any disputes. Understand that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision. To waive the right of notice or exemption within the state of Alabama or any other state in regard to personal property , allows one and one half (1½%) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Child's Name _____ Signature of parent/guardian _____

Date of signature _____

TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction 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 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. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

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)

Southern Pines Chiropractic Center
50 Manning Pl Birmingham, AL 35242
(205) 437-8837

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practice for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. Thereby give permission to Southern Pines Chiropractic Center (SPCC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to SPCC to use my address. Phone number and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If SPCC contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to SPCC to use my name on a welcome board, referral board, and birthday board.
- I give permission to SPCC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to SPCC to use any testimonial written by me for marketing purposes such as sharing
- with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give SPCC permission 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 information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving SPCC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Southern Pines Chiropractic Center plus 7 years or until revoked by me.

(more)

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of SPCC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by SPCC for its own use/disclosure of PHI.(Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, SPCC will not refuse to provide treatment however, it will not be possible for SPCC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since SPCC will be unable to contact me 3) all contact with SPCC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries the protected health information to be used/disclosed A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization form and acknowledge receipt of the Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____DOB:_____

My name (please print):_____

My Signature: _____

Today's Date: _____

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print): _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

_____