Kavanagh Chiropractic

Pediatric Pre-Exam Information

Patient:_____ Date:_____

1. Biographical Data

A. Patient Name:_____

B. Sex: M / F Date of Birth:_____ Age:_____

C. Mailing Address:_____

D. Street Address if different than Mailing Address:_____

E. Mother:_____ Occupation:_____

Address:_____ Phone:_____

F. Father:_____ Occupation:_____

Address: _____ Phone:_____

G. Siblings

Name:_____ Age:_____ Sex:_____

Name:_____ Age:_____ Sex:_____

Name:_____ Age:_____ Sex:_____

2. Family Medical History

Please check if any blood relatives to the patient had any of the following illnesses and mark accordingly by noting M (Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); MGM (Maternal Grandmother); PGF (Paternal Grandfather) or MGF (Maternal Grandfather).

____ Allergy, Asthma or Eczema	_____ Liver Disease	_____ Cancer
____ Mental Retardation	_____ Diabetes or Low Blood Sugar	_____ Mental Illness
____ Heart Trouble	_____ Scoliosis	_____ Ulcers
____ High Blood Pressure/ Stroke	_____Kidney Disease	_____ Other:_____

_____

3. Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy:

_____ Complications	_____Premature Contractions	_____Medications
_____ Back Pain	_____ Recreational Drugs	_____Other Pain
_____ Smoking	_____ Excessive Weight Loss	_____Excessive Weight Gain
_____Caffeine: Cola	_____ Toxic Exposures	_____Caffeine: Coffee
_____ Allergic Reactions	_____Caffeine: Chocolate	_____Caffeine: Tea
_____ Caffeine: Other	_____ Mental Trauma	_____Physical Injury
_____Prenatal Classes	_____ Vitamins/Minerals	_____Chiropractic Care
_____Hospitalization	_____Any Diagnosed Illness	_____Prenatal Care
_____ Immunization	_____ Carried to Full Term	_____Attitude: Mostly Happy
_____ Bleeding	_____ Attitude: Mostly Depressed	

4. Labor and Delivery

_____Greater than 12 Hours	_____ Caesarian	_____ Complications
_____Hospital	_____ Home Birth	_____ Medications
_____Premature Delivery	_____ Forceps	_____ Vacuum Extraction

_____Other:_____

5. Prenatal History – *If known please indicate*

The duration of the pregnancy was _____ weeks.
The apgar score at birth was _____. Apgar score at 5 minutes_____.
The length at birth was_____. The birth weight was_____.

Please check any problems that patient had at birth:

_____ Breathing _____ Nursing _____ Coloring _____ Sleeping
_____ Crying _____ Jaundice _____ Choking _____ Other:_____

Please check if any item (s) applied to the patient at birth:

_____ Medication _____ Surgery _____ Artificial Feeding _____ Vitamin K
_____ Erythromyocin _____ Circumcision _____ Other:_____

6. Nutrition

Please check if the patient has received any of the following items:

_____ Breast Milk _____ Sweets _____Commercial Formula _____ Juice: Fruit
_____Cow's Milk _____ Goat's Milk _____ Vitamins _____ Juice: Vegetable
_____Solid Foods _____ Medications _____ Other:_____

7. Immunization

Please list any immunizations the patient has received along with the date it was received and any reactions observed:_____

Foreign Travel and Dates:

8. Illnesses

Please list any illness(es) the patient has had along with date(s) of the illness(es) and any treatment received:_____

9. Family Physician

Name of pediatrician and date of last exam:_____

Clinic name and is location:_____

10. General System Review

1. Has your child ever been unconscious or had a convulsion?

2. Any problems with eyes, including vision?

3. Has your child ever turned blue or been cyanotic?

4. Does your child tolerate exercise?

5. Any recurring problem with vomiting, diarrhea, constipation or stomach pain?

6. Do the stools look or smell abnormal?

7. Any unusual problem on passing urine or any unusual frequency? Any unusual appearance or smell of the urine?

8. Does your child complain of any extremity or back pain? Do you notice a limp or unusual gait pattern?

9. Any allergies, eczema, hay fever, hives, asthma or drug reactions?

10. Other problems? Additional Information concerning specific items previously checked:

AUTHORIZATION TO RELEASE INFORMATION

Please read thoroughly, ***initial at each section*** and ***sign at the bottom***. Thank you.

HIPAA/Privacy Notices

Our Privacy Pledge: Kavanagh Chiropractic is concerned with and committed to the protection of our patient's privacy and ensuring the confidentiality of personal health information entrusted to us. Ways in which Kavanagh Chiropractic may disclose your health information, including but not limited to: treatment, diagnosis, 3rd party payor, billing, appointment reminders, or information about the clinic. You have the right, in writing, to limit uses or disclosures and to revoke your authorization. Authorization cannot be revoked if information has already been released. Without your consent, Kavanagh Chiropractic will not be able to submit claims to your insurance carriers or other third party payors and may not accept you as a patient.

X_____I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes. We may also use your information for reminder calls and mailings from our office.

Information about Possible Risk of Chiropractic Treatment

X_____You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries or physiotherapy burns. These are extremely rare occurrences.

Assignment of Benefits

X_____ I assign all benefits payable to me for my care to Kavanagh Chiropractic. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

X_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. Your insurance policy is an agreement between you and your insurance company, not between the insurance company and this chiropractic office. All benefits quoted are a general outline and are not a guarantee of payment. As a courtesy to our patients, the clinic will submit all eligible charges to the insurance company for the patient. It is to be understood that all services rendered are 100% the patient's responsibility. Cash patients are required to pay at each visit. Co-pays must be paid at each visit.

Consent for Treatment

X_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Cancellation

X_____A 24-hour notice must be given to reschedule or cancel a chiropractic appointment. If an appointment is missed, the patient must pay a $25 cancellation fee for the appointment. Insurance companies are not responsible to pay for missed appointments and will not be billed.

Nutritional Supplements/Orthopedic Supports

X_____All supplements/vitamins and orthopedic supports or supplies must be paid IN FULL at time of service. Supplements/vitamins are non-returnable.

Authorization to Treat a Minor (under the age of 18)

X_____I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other 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 anyway, I will immediately notify Kavanagh Chiropractic.

Name (Printed):_____ Date:_____

Signature of Patient or Responsible Party:_____ Relationship to Patient:_____