Child's Health History

FOUNDATION CHIROPRACTIC

CHILD'S PERSONAL DATA

Today's Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Home Address: _____ City: _____State/Zip: _____

Names & Ages of Siblings: _____

Parent A	Parent B
Name: _____	Name: _____
Phone: (_____) _____	Phone: (_____) _____
Employer: _____	Employer: _____
E-Mail: _____	E-Mail: _____

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

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Foundation Chiropractic can address for your child?

_____

_____

Are these concerns affecting your child's quality of life?

Attention/Focus:	☐ Y	☐ N	School:	☐ Y	☐ N	Sleep:	☐ Y	☐ N
Communication:	☐ Y	☐ N	Walking:	☐ Y	☐ N	Daily Routine:	☐ Y	☐ N
Exercise/Sports:	☐ Y	☐ N	Eating:	☐ Y	☐ N	Playing:	☐ Y	☐ N

Other: _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ☐ Y ☐ N Name of D.C. _____

Reason for care: _____

How long under care? ☐ _____ days ☐ _____ weeks ☐ _____ months ☐ _____ years

Date of last visit: _____ Why did you stop care? _____

Have you consulted any of the providers below for your child? *(check all that apply)*

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ OT/PT
☐ Massage Therapist ☐ Psychotherapist ☐ Dentist ☐ Other

Reason: _____

Health, Vitality, & Chiropractic Care

The primary system in the body which coordinates health is the **nerve system**. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called **vertebral subluxation**. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional and chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses your child has been subjected to in his/her life and how they may be related to his/her present spinal, nerve and health status and whether they may have caused vertebral subluxations to occur.

PREGNANCY & BIRTH

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system.

During pregnancy did the mother:

Experience any illnesses, difficulties, or trauma? ☐ Y ☐ N List: _____

Take any drugs/medications? ☐ Y ☐ N List: _____

Smoke or consume alcohol? ☐ Y ☐ N List: _____

Was the delivery premature? ☐ Y ☐ N Weeks: _____ Weight: _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ☐ Y ☐ N

Was the child in a breech position (butt down) or otherwise mispositioned? ☐ Y ☐ N

Please check where the child was born & if any of the following were administered during labor & birth:

☐ Home birth	☐ Vaginal	☐ Pitocin	☐ Suction
☐ Water birth	☐ Caesarian	☐ Episiotomy	☐ Manual traction of neck
☐ Hospital birth	☐ Epidural	☐ Vacuum	☐ Medications: _____

Please check all that apply to the child's status immediately after birth:

☐ Jaundice	☐ Respiratory problems	☐ Broken bones
☐ Displaced joints	☐ Feeding problem	☐ Other conditions: _____

Was the baby breastfed? ☐ Y ☐ N For how long? _____ APGAR Score (if known): _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

☐ Been in an automobile accident	☐ Has fractured a bone or dislocated a joint
☐ Has/had a chronic illness	☐ Has had surgery
☐ Uncoordinated/ Accident prone	☐ Has been hospitalized
☐ Had a severe trauma or concussion	

What physical activities does your child participate in?

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ☐ Y ☐ N

If yes, please check all vaccinations the child has received and at what age they were administered:

☐ DPT _____ ☐ Hepatitis _____ ☐ Chicken Pox _____

☐ Polio _____ ☐ MMR _____ ☐ Flu _____

☐ Other _____

Please describe any reactions to vaccine(s)

Please check all that apply and give any necessary details:

☐ Child has been exposed to secondhand smoke.

☐ Has taken antibiotics. Explain: _____

☐ Currently taking medication. Explain: _____

☐ Currently taking supplements. Explain: _____

☐ Has allergies. Explain: _____

What treatments have you used? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is experiencing any of the emotional stresses below:

☐ Academic pressure ☐ Bullying ☐ Parents' divorce ☐ Loss of a pet

☐ Loss of a loved one ☐ New sibling ☐ Lifestyle change ☐ Relocation

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like my child to experience the following benefits from Chiropractic Care: *(Check all that apply)*

☐ Symptomatic relief of a problem

☐ Prevention of future problems

☐ Healthier spine and nerve system

☐ Optimal health on all levels

☐ Other: _____

Thank you for choosing Foundation Chiropractic!

Finances

FOUNDATION
CHIROPRACTIC

Payment in full is expected on all FIRST VISIT services.

First Visit Fees: Comprehensive Exam: $200 (Ages 13+) | Prenatal Exam: $150 | Child Exam $75 (Ages 0-12)

Please indicate your method of payment: ☐ Cash ☐ Check ☐ Credit Card ☐ HSA ☐ FSA

Our Approach to Finances at Foundation Chiropractic

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. We utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary (as determined by your chiropractic evaluation) at affordable fees.

Insurance

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with *itemized statements for you to submit upon request*.

Are you consulting us for an Auto Accident Related Injury?

If yes, please provide us with the following information:

Date of Injury: _____ Has your child been treated for injuries? ☐ Yes ☐ No

If yes, where? ☐ Emergency Room ☐ Primary Care ☐ Chiropractor

What services were provided? ☐ MRI ☐ X-Rays ☐ Medication ☐ Therapy

NOTE: You may be required to pay for all services until we receive approval and payment from the insurance carrier.

The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. All parents/guardians in charge of medical decisions for this child agree to allow our office to assess and provide chiropractic care.

Child's Name (printed): _____

Parent or Legal Guardian's Name (printed): _____

Signature of Parent: _____ Date: _____

ChiroFutures

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science, which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship

Initials:

between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE FOUNDATION CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ___ DAY OF _____, 20__

_____ _____

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for:

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for:

Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks:

FOUNDATION
CHIROPRACTIC

907 Honea Egypt Road, Magnolia, TX 77354
832-458-3004

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices 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. I hereby give permission to Foundation Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Foundation Chiropractic to use my email address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Foundation Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to Foundation Chiropractic to use my name on a welcome board, referral board, and birthday board.
- I give permission to Foundation Chiropractic 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 Foundation Chiropractic 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 Foundation Chiropractic 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 doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Foundation Chiropractic 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 Foundation Chiropractic plus 7 years or until revoked by me.

Initials:

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 Foundation Chiropractic (Dr. Evan Pulver).
The written notice must contain the following information:

- Your name
- Date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

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

This AUTHORIZATION is requested by Foundation Chiropractic 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,

Foundation Chiropractic will not refuse to provide treatment however, it will not be possible for Foundation Chiropractic to respond to third party billing on my behalf and I will be responsible for 1) scheduling my own appointments since Foundation Chiropractic will be unable to contact me 2) all contact with Foundation Chiropractic 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.

Date of Birth: _____

Patient's Name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor):

Parent or Personal Representative name (please print):

Signature:

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

_____