Patient # _____

Contour Chiropractic

Dedicated to Quality Care

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Child & Adolescent Case History

Name: _____ Today's Date: _____

Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Phone: _____ Work: _____ Ext: _____

Siblings & Ages: _____

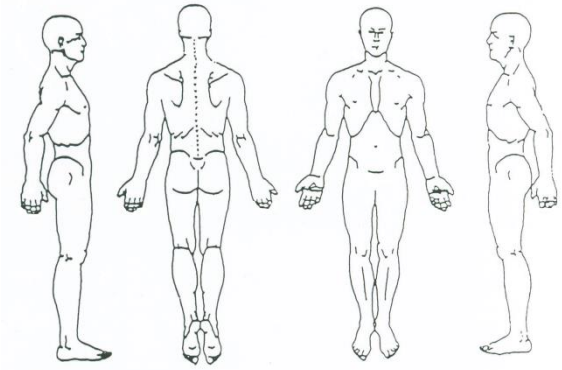
Referred By: _____

Does your child feel pain at this time? Yes / No

Was your child involved in a motor vehicle accident? Yes / No If Yes, when: _____

(If the nature of your child's visit today is due to a motor vehicle accident, you will need to fill out a MVA form as well)

If yes, please mark on the body diagram where your child feels the pain and briefly describe their symptoms:



Please rate your child's pain 0 = No Pain, 10 = Severe Pain

0 1 2 3 4 5 6 7 8 9 10

_____

_____

_____

_____

_____

**Office Use Only: Reviewed with the patient & parent/guardian on _____/_____/_____ .

_____

Office Use Only:

1st Condition:
O:
Pal:
Pro:
Quality:
Quantity:
Rad:
Site:
Time:
PC:

2nd Condition:
O:
Pal:
Pro:
Quality:
Quantity:
Rad:
Site:
Time:
PC:

SECTION 1: MOTHER'S HISTORY of PREGNANCY AND CHILD'S DELIVERY

Place of Birth: _____ Hospital / Home Birth / Other: _____

Did you have ultrasound(s) during this pregnancy? Yes / No Frequency & type: _____

Did you carry to full term? Yes / No If no, why not: _____

Was it a difficult pregnancy? Yes / No Type of Birth: ____ Natural ____ Cesarean – Section

Was the delivery induced? Yes / No Did you have an epidural? Yes / No

Were forceps used? Yes / No Vacuum extraction? Yes / No

Describe any complications and when they occurred: _____

_____

_____

Did you consume any alcohol during your pregnancy? Yes / No

If so, how much? _____

Did you smoke during your pregnancy? Yes / No

If so, how many per day / week approximately? _____

Did you take any medication during your pregnancy? Yes / No If yes, what was it and list dosage below:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

SECTION 2: YOUR CHILD'S DEVELOPMENT

Has your child ever been checked by a Doctor of Chiropractic? Yes / No

Who? _____ X-rays? Yes / No Date of X-rays: _____

Who is your child's regular Pediatrician? _____ Phone: _____

As a baby/toddler (birth to year four), did any of the following occur?

- ❑ Frequent crying spells
- ❑ Frequent fevers
- ❑ Frequent colds
- ❑ Sleeping problems
- ❑ Involved in a car accident
- ❑ Any Surgery: Y / N when: _____ What for: _____
- ❑ Frequent bouts of diarrhea
- ❑ Frequent ear infections
- ❑ Tonsillitis
- ❑ Colic
- ❑ Antibiotic use
- ❑ Any falls
- ❑ Latching difficulties
- ❑ Trouble nursing
- ❑ Preference to certain breast
- ❑ Falls asleep nursing

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Please list any childhood illness:_____

_____

_____

As a child (5 years to present), have any of the following occurred?

- ❑ Asthma
- ❑ Bed wetting
- ❑ Allergies or Hay fever
- ❑ Stomach problems
- ❑ "Growing Pains"
- ❑ Low back pains
- ❑ Involved in a car accident
- ❑ Neck Pain
- ❑ Ringing in the ears
- ❑ Sleeping difficulties
- ❑ Numbness or tingling
- ❑ Hyperactivity (ADD/ADHD)
- ❑ Any period of hospitalization
- ❑ Headaches
- ❑ Dizziness
- ❑ Fatigue
- ❑ Sports injury
- ❑ Any surgery

Which of the above problems is the worst?_____

_____

How long has this problem persisted?_____

_____

List any medications that your child is currently taking:_____

_____

Is there anything else that you feel we should know about?_____

_____

_____

What do you hope to gain from this appointment?_____

_____

_____

_____ _____

Signature of Parent/Legal Guardian Date

RADIOLOGICAL CONSENT

Notice to all parents: In general we do not x-ray children under the age of 8 unless there is necessity. You will be notified in advanced before any x-rays will be taken.

I _____ do herby give my consent to allow Contour Chiropractic and it's representatives, as deemed necessary by the examining physician to take radiographic images of my child's spine and or extremities.

_____ _____

Signature of Parent/Legal Guardian Date

***(**Females only**) I also hereby declare that to my knowledge that I am not pregnant _____ (Initial) ____/____/_____*

Date of Last Period

***Office Use Only: Reviewed with the patient & parent/guardian on ____/____/_____. _____*

Payment / Insurance Information

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carried and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

***Patients Signature**_____ **Date**____/__ __/__ ____

***Guardian or Spouse's Signature Authorizing Care**_____**Date**____/__ __/__ ____
I hereby authorize Contour Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Primary Insurance Co. Name:_____ Policy #_____

Address_____ Phone #_____

Insured's Name_____ Insured's SS#_____

Relationship to Insured_____ Insured DOB____/__ __/__ ____

Employer_____

For Automobile Accidents, include Policy Claim No._____

Do you have a Secondary Insurance? ❑ Yes ❑ No With whom: _____

Who should receive charges on your account?

❑ Patient ❑ Parent/Guardian ❑ Auto Insurance ❑ Attorney

Please make sure that you provide us with your insurance cards so that we may be able to verify your coverage.

Authorization of Care

I authorize and agree to allow the doctor and/or chiropractic assistant to work with my spine through the use of spinal adjustments, and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and or/ chiropractic assistant will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or chiropractic assistants specific recommendations at this clinic that I will not receive full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorized the assignment of all insurance benefits be directed to the doctor for all services rendered.

_____ _____ _____
Patient's Name Printed Patient's Signature Date

_____ _____ _____
Minors Name Guardian/Spouse's Signature Authorizing Care for Minor Date

HEALTHCARE AUTHORIZATION FORM

HIPAA Required Form

THE FOLLOWING AUTHORIZES CONTOUR CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

I give permission to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assures that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

I give permission to Contour Chiropractic to use my name, address, phone number and clinical records to contact me with recall postcards, thank you cards, welcome cards, birthday cards, holiday related cards health related e-mail messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Contour Chiropractic 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 protective health care information during the course of my treatment. Should I need to speak with a doctor or chiropractic assistant in private, the doctor or assistant will provide a private room for these conversations.

A patient's written consent need only be obtain a one time for all subsequent care given the patient in this office.

If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I _____ have read and understand how my Patient Health Information will be used and I agree to these policies and procedures, I also understand that I have the following rights and privileges:

* The right to object to the use of my health care information for directory purposes
* The right to request to know what disclosures have been made and submit in writing any further restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations. Our office is not obligated to agree to those restrictions.
* The right to examine and obtain a copy of my health records at any time and request corrections.

_____ _____

Signature **Date**

_____

Print Name

Signed form received by: _____ Date: _____