Pediatric Patient Information & History

We are pleased to welcome you to Advanced Spinal Fitness. Please take a few minutes to complete your child's health profile as completely as you can. If you have questions, we'll be glad to assist you. We look forward to helping you and your family achieve maximum health through Chiropractic.

Name _____ Birth Date _____ Gender: M F

Address_____ State _____ Zip _____

Parent's Cell Phone # _____ Alternate Phone # _____

Parent's Name _____ Parent's Email _____

Hobbies/Interests/Sports _____

Name of your M.D./D.O. _____ City _____ Phone _____

This Account is paid by: You &: Auto Ins. Other

Whom may we thank for referring you to Advanced Spinal Fitness? _____

Reason for Visit

Your reason for this visit: Specific Problem Prevention Wellness / Maximize Health Potential

Please list your child's symptoms / complaints (if any):

_____

_____

Please list other care undergone for this complain, including medications: _____

_____

Has your child ever seen a Chiropractor? Yes No If yes, when and describe your experience? _____

_____

Please circle all that apply, regarding your child's Chief Complaint:

Date of Onset of Problem: ____ / ____ / ____ **Onset was:** Sudden Gradual Associated with an Event

Duration of Problem: ____ days / months / years **Pattern of Problem:** Constant Intermittent Occasional Cyclical

Is Pain getting: Worse Better Same **What makes the problem worse?** _____ **Better?** _____

Is Pain Interfering with: School Hobbies Sports Family Sitting Standing Walking Sleeping Eating Concentrating Other: _____

Please list any other concerns, current or past: _____

Does your child have a family history of: Cancer Diabetes Heart Disease Stroke High Blood Pressure

Please complete the following sentences:

I am here because _____

My goal (s) for care is (are) _____

Health History & Health Habits

Birth History:

Location: Home Birthing Center Hospital **Provider**: Midwife OB/GYN None **Duration of Gestation**: _____weeks
Please Circle any that apply: Induction Forceps Vacuum Extraction C-Section **Duration of Birth**: _____
Medications given to Mother during labor / delivery? Yes No If yes, what? _____
Describe any complications during or immediate after birth: _____
APGAR at Birth: _____ **After 5 Minutes:** _____ **Birth Weight:** _____ **Birth Length:** _____
Was your child alert and responsive within 12 hours after deliver? Yes No **If No, explain:** _____

Growth & Development

At what age did your child: Respond to Sound _____ Follow an Object _____ Hold up Head _____ Vocalize _____
Sit Alone _____ Crawl _____ Walk _____
Do sleeping patterns seem normal to you? Yes No **If no, explain:** _____
Number of bowel movements per day: _____ **Consistency of stools** (firm, loose, normal):_____

Chemical History

Was your child breast-fed? Yes No **How long?** _____ **Formula introduced at age** _____
Solid Food at age _____**Any food / juice allergy or intolerance?** Yes No **If yes, what foods:** _____
During pregnancy did the mother smoke? Yes No **Drink alcohol?** Yes No **Use recreational drugs?** Yes No
Please list any illness of the mother during pregnancy: _____
Any drugs or supplements taken by the mother during pregnancy: _____
Any exposure to ultrasound? Yes No **If yes, how many and what was the medical reason?** _____
Any invasive procedures (amniocentesis, CVS)? Yes No **If yes, give reason:**_____
Any smokers living in the home? Yes No **Exposure to fluoride (water, toothpaste)?** Yes No
Child's sugar consumption (soft drinks, candy, etc.) None Low Medium High
Has your child had any vaccinations? Yes No **If yes, any adverse vaccine reactions?** Yes No
Please list all drugs or supplements your child is currently taking: _____
Has your child ever taken antibiotics? Yes No **If yes, how many times?** _____

Social History

Circle if your child has had problems with any of the following: Breast-feeding Bonding Nightmares/Difficulty Sleeping
Making/Keeping Friends Depression
Any behavioral problems? Yes No **If yes, please describe:** _____

Trauma History

Any traumas during pregnancy? Yes No **Any evidence of birth trauma**? **(bruises, odd head shape, fast or excessively long birth, cord around neck, torticollis, collar bone damage, etc.)** Yes No **If yes, what kind:** _____
List significant falls or impacts (from changing tables, trees, ladders, bikes, car accidents, etc.) _____
List any traumas requiring stitches, casts, etc.: _____
List any hospitalizations or surgeries: _____
List any ports played, including # hours per week played: _____
Age your child began sports: _____ **Approximate weight of school backpack:** _____
Please list any questions you have: _____
_____

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate through use of chiropractic manipulation throughout my spine and/or extremities. Ay x-ray negatives will remain the proper of this office, being on file where they may be seen at any time while a patient at this office. The patient also agrees that he or she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medially diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

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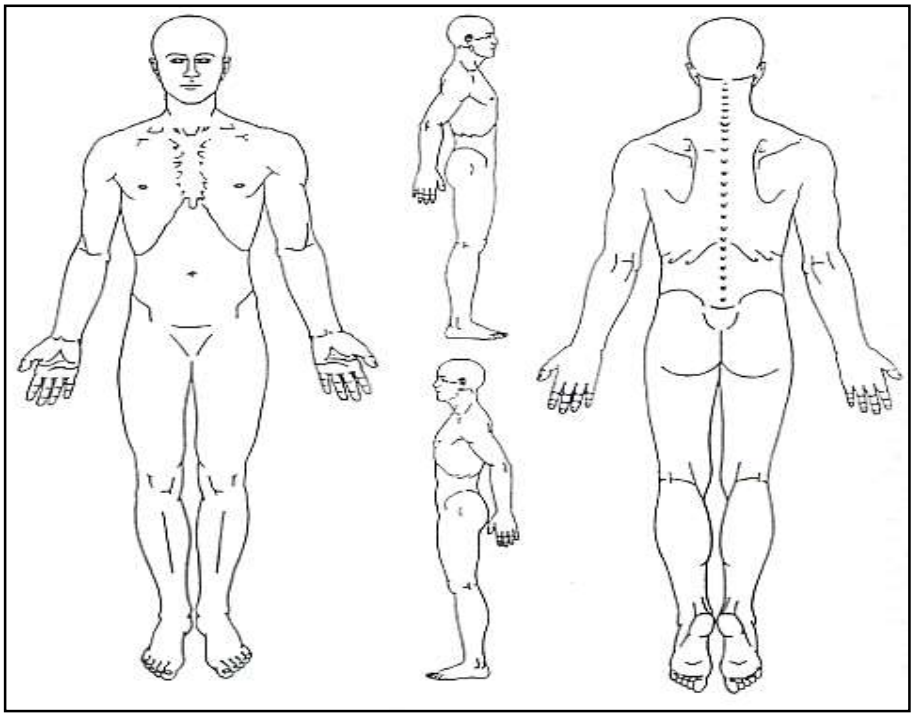
Pain Disability Diagram

Name: _____ Date: _____DOB: _____ Patient #: _____

Please circle the locations of your symptoms on the drawings. Also note the intensity and frequency of pain on the lines below. A one to ten scale is provided at the bottom for your reference. Use the blank lines for any areas of pain not named on the list.



1. **Headaches** Intensity: _____ Frequency: _____ days per week
2. **Neck Pain** Intensity: _____ Frequency: _____ days per week
3. **Arm Pain** Intensity: _____ Frequency: _____ days per week
4. **Upper-back Pain** Intensity: _____ Frequency: _____ days per week
5. **Mid-back Pain** Intensity: _____ Frequency: _____ days per week
7. **Low Back Pain** Intensity: _____ Frequency: _____ days per week
8. **Hip / Buttocks** Intensity: _____ Frequency: _____ days per week
9. **Leg Pain** Intensity: _____ Frequency: _____ days per week

_____ Intensity: _____ Frequency: _____ days per week

_____ Intensity: _____ Frequency: _____ days per week

Intensity Scale:

0 = No Pain
1-3 = Mild Pain
4-6 = Moderate Pain
7-9 = Severe Pain
10 = Maximum Pain

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Informed Consent to Treatment

All common health care treatments, including surgery, medications, injections, and spinal manipulation may have some risks associated with them. Doctors of Chiropractic are required to inform their patients regarding those possible risks. Please be informed of the following:

The most common side effect of chiropractic spinal or extremity manipulation is short term stiffness/soreness and/or headache. This side effect does not occur in every patient, is usually mild or moderate, but can occasionally be severe. This side effect is most commonly seen after the first several treatments and generally diminishes as treatment continues. Every care and precaution is taken in choosing adjustment style to minimize this side effect. Please inform your doctor if you experience any of the above.

While rare, some patients may experience muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

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 between chiropractic treatment and the occurrence of stroke. Recent studies suggest that many patients may be consulting medical doctors and chiropractors with pain symptoms when they are in the early stages of a stroke. In essence, there is a stroke already in progress before treatment. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years, and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatments, medications, and procedures given for the same symptoms.

I acknowledge that I have read this consent and will discuss with my chiropractor any questions I have about the nature and purpose of chiropractic treatment in general and my treatment, as well as the contents of this consent. _____ (Initials)

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. In the event of the Doctors absence, I extend this consent to the chiropractic colleagues within this clinic. I intend this consent to apply to all my present and future care.

_____
Patient Name (Please Print)
(Parent/Guardian if Patient is a Minor)

_____ _____
Signature of Patient/Parent/Guardian **Date**

Acknowledgement of Privacy Policies

I hereby acknowledge that I have received a copy of the Advanced Spinal Fitness privacy policies. I understand that if I am not in agreement with the policies outlined, I am to speak with a representative of Advanced Spinal Fitness to make my concerns known and to revise the privacy policy as it applies to my protected health information, if possible.

_____
Patient Name (Please Print)
(Parent/Guardian if Patient is a Minor)

_____ _____
Signature of Patient/Parent/Guardian **Date**

Privacy Policies

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

In the course of your care as a patient at Advanced Spinal Fitness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

This office may use name boards to acknowledge patients for referrals and birthdays in open areas where others may view your name only. No other Protected Health information would be used. You may also occasionally receive a nominal gift from this office.

Periodically, you may receive newsletters from this practice that highlight practice activities and information on products and services that will benefit your health.

You will have the opportunity to talk to your doctor and staff members in private. However, this practice provides treatment in an open area. This means that statements made by you or practice employees during treatment may be overheard by others. In addition, you will likely receive treatment within sight of other patients. If you have comments you wish to make privately when you are brought to the treatment area or during treatment, please inform the doctor or staff and we will accommodate your request. This open environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. You have the right to receive your ongoing care in a private setting. If you would like to be accommodated in this way, make the staff and/or doctor aware of this preference.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy policies with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy policy will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you may direct your complaint to the Secretary of Health and Human Services, or you may notify our staff of any complaint. We will not retaliate against you for filing a complaint. Direct any complaints or requests for further information about our privacy policies and practices to Dr. Nicole Whitehead.

This notice is effective as of January 15, 2007

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