Confidential Pediatric Patient History

Date ______________________

Last ______________________ First ______________________ MI ________ Birthdate ________________ Age ________

Address ______________________________________ City ______________________ State ________ ZIP ________

Home Phone ______________________ Work Phone ______________________ Cell Phone ______________________

Parent/Guardian Email ______________________________ May we send you our email appointment reminders? ☐ Yes ☐ No

Parents' Name ________________ Birthdate ____________ Phone ____________ Employer ______________________

Has your child had previous Chiropractic care? ☐ Yes ☐ No Provider? ______________________________

Who may we thank for referring you to our office? ______________________ ☐ Walk-in ☐ Facebook ☐ Website ☐ Insurance

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Insurance

☐ Self Pay ☐ Primary Insurance ______________________ Responsible party? ______________________

Card ID# ______________________________ Group # ______________________________

Deductible ________________ Copay ________________ Coinsurance ______________________

General Questions/Prenatal History:

Any complications during pregnancy? ☐ Yes ☐ No Explain: ______________________________

Medications taken during pregnancy: ______________________ Cigarettes or alcohol during pregnancy: ☐ Yes ☐ No

Birth Interventions: ☐ Forcepts ☐ Vacuum ☐ C-Section

Any complications during delivery? ☐ Yes ☐ No Explain: ______________________________

Genetic disorders or disabilities: ______________________________

How many times has your child been prescribed antibiotics in the past 6 months?: ____________ Total during lifetime: ____________

Has your child received vaccinations? ☐ Yes ☐ No

Primary complaint: ______________________________

Feeding History

Breast Fed: ☐ Yes ☐ No How long: ________________

Formula Fed: ☐ Yes ☐ No How long: ________________

Introduced to: Solids at ________________ Months

Introduced to: Cow's milk at ________________ Months

Food Allergies or Intolerances: ☐ Yes ☐ No

List: ______________________________

Childhood Diseases:

Chicken Pox: ☐ Yes ☐ No Age: ____________

Rubella: ☐ Yes ☐ No Age: ____________

Rubeola: ☐ Yes ☐ No Age: ____________

Mumps: ☐ Yes ☐ No Age: ____________

Whooping Cough: ☐ Yes ☐ No Age: ____________

Other: ____________ Age: ____________

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Injury/Accident History

Has your child had any falls or head trauma? ☐ Yes ☐ No
Explain: ______________________________

Has your child been involved in any high impact or contact type of sports? ☐ Yes ☐ No
Explain: ______________________________

Has your child ever been involved in a car accident? ☐ Yes ☐ No
Explain: ______________________________

Any other traumas not described above? ☐ Yes ☐ No Explain: ______________________________

Prior Surgery? ☐ Yes ☐ No Explain: ______________________________

Review of Systems

☐ Headaches
☐ Asthma
☐ Digestive Problems
☐ Colic
☐ Postural Inbalances
☐ Torticollis
☐ Bedwetting
☐ Learning Difficulties
☐ Growing Pains
☐ Ear Infections
☐ PDD/Autism
☐ Acid Reflex
☐ Scoliosis
☐ Seizures
☐ ADD/ADHD
☐ Hip Dysplasia
☐ Tonsillitis
☐ Sleep Problems
☐ Frequent Fever
☐ Allergies

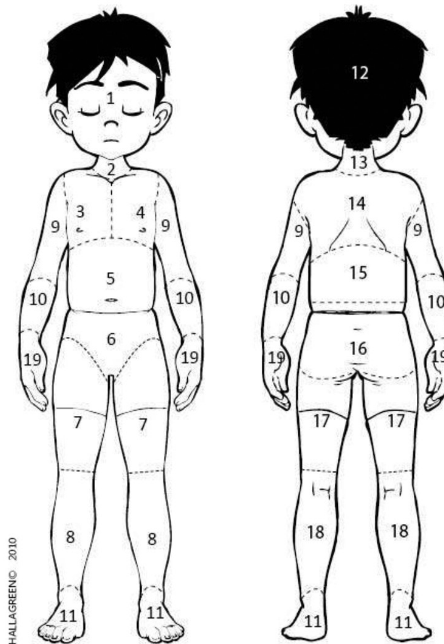
Rate your childs diet: ☐ Well Balanced ☐ Average ☐ High Sugar/Processed Foods

Number of hours your child sleeps: __________ Hours per night: __________ Hours per day/naps: __________

Rate your childs sleep quality: ☐ Good ☐ Fair ☐ Poor

Imagine this picture is your childs body.
Color the area that is hurting.

1 - Face
2 - Neck
3 - Left Chest
4 - Right Chest
5 - Stomach
6 - Abdomen
7 - Thighs
8 - Legs
9 - Upper Arms
10 - Lower Arms
11 - Feet
12 - Back of Head
13 - Back of Neck
14 - Upper Back
15 - Middle Back
16 - Lower Back
17 - Back of Thighs
18 - Back of Legs
19 - Hands



Authorization to Treat a Minor

I, ______________________________ the undersigning parent/guardian having legal custody/guardianship of ______________________________, a minor, do hearby authorize, request and direct Dr. Chonzena and whomever he might designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Parent/Guardian ______________________________ ______________________________ Date __________
Print Name Signature

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Notice Of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and/or copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number.

Our Notice of Privacy Practices describes in more detail how your health information may be used, disclosed, and how you can access your information.

By my signature below I acknowledge the receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature — Date

Printed name if signed on behalf of the patient — Relationship

(parent, legal guardian, personal representative.)

Staff Notes:

This from will be retained in your medical record.

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PATIENT COPY —— FOR YOUR RECORDS

Date ______________________

Notice Of Patient Privacy

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office at 360-568-3319.

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of manual therapy and referral for diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure with the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I will have an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature of the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, mild to severe bruising or minor complications.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, ______________________________ being the parent or legal guardian of ______________________ have read and full understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Patient/Parent/Guardian Signature | Date