

Chart # \_\_\_\_\_

Pediatric History Form

Dear Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information for your child. We look forward to working with you to build a better, healthier family.

Childs Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Home Phone: \_\_\_\_\_ Your Work/Cell # \_\_\_\_\_

Sex: M/F Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Referred BY: \_\_\_\_\_

Parents/Guardian Names: \_\_\_\_\_

Purpose for contacting us: \_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_\_

Treatments given: \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months.

- Ear Infections
- Asthma/Allergies
- Colic
- Digestive Problems
- Bed Wetting
- Seizures
- ADHD
- Car Accident
- Recurring Fevers
- Temper Tantrums
- Scoliosis
- Other \_\_\_\_\_
- Headaches/Migraines
- Back Pain
- Chronic Colds

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems Stroke

Previous Chiropractic Care: \_\_\_\_\_ Date of Last Visit \_\_\_/\_\_\_/\_\_\_ Reason \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Date of Last Visit: \_\_\_/\_\_\_/\_\_\_

Reason: \_\_\_\_\_ Are you satisfied with the care your child receives there? Y / N

Number of doses of antibiotics your child has taken: Last 6 Months: \_\_\_\_\_ Total in Lifetime: \_\_\_\_\_

Number of doses of other medications your child has taken: Last 6 Months: \_\_\_\_\_ Total in Lifetime: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

Prenatal History:

Name of Obstetrician/Gyn/Midwife: \_\_\_\_\_

Complications during pregnancy: Yes \_\_\_\_\_ No \_\_\_\_\_

Ultrasounds during pregnancy: Yes? How Many \_\_\_\_\_ No \_\_\_\_\_

Medications during pregnancy/delivery: Yes \_\_\_\_\_ No \_\_\_\_\_

Cigarette/Alcohol use during pregnancy: Yes \_\_\_\_\_ No \_\_\_\_\_

State of Birth \_\_\_\_\_ Hospital \_\_\_\_\_ Birth Weight \_\_\_\_\_ Length \_\_\_\_\_

Intervention: \_\_\_\_\_ Forceps: \_\_\_\_\_ Vacuum Extraction: \_\_\_\_\_ Caesarian Section \_\_\_\_\_ Emergency or Planned? \_\_\_\_\_

Genetic disorder or disabilities? Y / N List \_\_\_\_\_

Chart #: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Feeding History:

Breast Fed: Y / N How Long? \_\_\_\_\_ Formula Fed: Y / N How Long? \_\_\_\_\_ What Type? \_\_\_\_\_

Introduced to solids at \_\_\_\_\_ months Cow's milk at \_\_\_\_\_ months

Any juice or food allergies: Y / N List: \_\_\_\_\_

Developmental History:

During the following times your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to do the following?

\_\_\_\_\_ Respond to Sound \_\_\_\_\_ Cross Crawl \_\_\_\_\_ Stand Alone

\_\_\_\_\_ Respond to Visual Stimuli \_\_\_\_\_ Sit Up \_\_\_\_\_ Walk Alone

\_\_\_\_\_ Hold Head Up

According to the national safety council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down steps, etc).

Has this ever happened to your child? Y / N. If so, When \_\_\_\_\_

Is/Has your child ever been involved in any high impact or contact sports such as soccer, football, gymnastics, baseball, cheerleading, martial arts, etc. Y / N If yes, what type of activities? \_\_\_\_\_

Has your child ever been in an automobile accident? Y / N If so, when \_\_\_\_\_

Has your child ever been seen on an emergency basis at the ER? Y / N If so, for what? \_\_\_\_\_

Any other traumas not listed previously? Y / N If so, what type? \_\_\_\_\_

Any prior surgery to report? Y / N If so, what type? \_\_\_\_\_ When? \_\_\_\_\_

If female child, has daughter begun menses? Y / N If so, what age? \_\_\_\_\_

Childhood Diseases:

Chicken Pox---Age \_\_\_\_\_

Mumps---Age \_\_\_\_\_

Rubella---Age \_\_\_\_\_

Rubeola---Age \_\_\_\_\_

Whooping Cough---Age \_\_\_\_\_

Other \_\_\_\_\_ Age \_\_\_\_\_

We are here to serve you and encourage you to ask questions. Your participation is vital and will help determine your results. Thank you for taking the time to complete the necessary forms.

Authorization To Treat A Minor

I hereby authorize this office and its Doctors of Chiropractic to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date.

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Chart #: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_

## Medication/Supplement List

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamin/Supplement Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Chart # \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**Santoro Chiropractic P.C.  
1177 South 6<sup>th</sup> Street Suite D  
Indiana, Pa 15701**

**Informed Consent for Chiropractic Treatment**

*To the patient: You have a right to be informed about your condition, the recommended chiropractic treatment and potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I hereby request and consent to the performance of chiropractic adjustments, procedures, therapies and diagnostic x-rays. The treatment may be performed by Dr. Jeannie Santoro or by a doctor of chiropractic at Santoro Chiropractic P.C.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all the risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which she feels as the time is based upon the facts then known, is in my best interest. I have had opportunity to discuss the risk and benefits of alternative treatment, including no treatment at all.

I have been advised that there are also other risks, including but not limited to fractures, disc injuries, strokes, dislocations sprains/strains, worsening of spinal conditions, increased symptoms, no improvement of symptoms, soreness of muscles, burns, and frostbite therapy in therapy.

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movements) and death. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care.

I have read or have had read to me the above consent. I have had an opportunity to ask questions about its contents, and by signing below agree to the chiropractic adjustment procedures and care. I intend this consent form to cover the entire course of treatment.

\_\_\_\_\_  
**PRINT Patient Name**

\_\_\_\_\_  
**Signed Patient Name, non- minor**

\_\_\_\_\_  
**PRINT Parent/ Guardian Name** for minor patient

\_\_\_\_\_  
**Signed Parent/ Guardian Name** for minor patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

Chart # \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Patient Health Information Policies for  
Santoro Chiropractic P.C.**

The patient understands and agrees to allow Santoro Chiropractic P.C. to use his/her Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.

The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his/her PHI. The office will not release any of your records without your written permission.

The patient or guardian consents to use patient's name for the purpose of welcomes, Referrals, Testimonials, Kids photo boards, Birthdays, strictly for special acknowledgements.

I have read and received a copy of the Notice of Privacy Practices for Santoro Chiropractic P.C.

I have read and understand how my (or my dependent's) PHI will be used and agree to these policies and procedures.

\_\_\_\_\_  
Patients or Guardian Signature

\_\_\_\_\_  
Date

**Santoro Chiropractic P.C. Patient Information and Office Policy**

Our goals are three fold: relieve your symptoms, achieve correction, and maintain health. We will attempt to achieve this with specific, compassionate care, in the shortest amount of time as possible.

Often the doctor recommends a series of appointments, and we encourage you to schedule multiple appointments in advance. This is best for your schedule as well as ours. If you need to reschedule, please call in advance so not miss an appointment, but make it up at another time. We will do our best to be as close to your appointment time as possible, and we ask you to be considerate of other patients and arrive promptly as well.

Santoro Chiropractic P.C. will do a special "no charge" consultation with anyone interested in Chiropractic care. There is no charge or obligation in connection with this appointment and is designed to determine if Chiropractic care may help your individual health problem. This does not include an exam or x-rays.

Patient payment policies:

We feel that patient's health needs are paramount; therefore, the payment policy is an attempt to allow you, the patient, to receive the care you need and pay your balance in the least amount of difficulty.

We require that you pay for your visit before being seen by the doctor. The doctor will often make a payment plan that works with your schedule of visits. Doing this saves us all time and your money. There will be a \$30 fee for any returned checks.

We require 20% of the first visit charges due on the first day of service. The balance of these charges can be made in payments unless we will be billing your insurance company. Properly documented Workers Compensation, and Personal Injury claims are not required to pay at this time if appropriate forms and liens are signed.

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Established patient care services:**

Patients with unpaid balances are required to make regular payments. A finance charge of 1% (one percent) per month is charged on all accounts in which no payment has been received for 60 days or more. You will receive a monthly statement with all your charges and payments itemized. Please review this and retain it for your records.

**Our policy on health insurance:**

Today most insurance policies do cover Chiropractic care. We will be happy to process all insurance paperwork on your behalf.

**Authorization to release medical information to individuals/family members:**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Santoro Chiropractic to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give you authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_ I **do not** authorize Santoro Chiropractic PC to release any or all information concerning my medical care to any individual concerning my medical care to any individual except as set for above.

\_\_\_\_\_ I **do** authorize Santoro Chiropractic PC to verbally release any or all information concerning my medical care to the following individuals:

_____	_____	_____	_____
Name	Relationship to patient	Phone # Home	Cell

_____	_____	_____	_____
Name	Relationship to patient	Phone # Home	Cell

Please let us know if you have any questions, or if we can be of any further assistance at any time!

I have read the above Santoro Chiropractic P.C. Patient Information and fully understand the statements.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

Chart # \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_\_

**Notice of Privacy Practices for Santoro Chiropractic P.C.**

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

**How your Health Information may be used:**

**To Provide Treatment:** We will use your health Information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between this office and that of referring physicians, clinical and pathology laboratories and other health care personnel providing you treatment. It may be necessary to seek consultation regarding your condition from other health care providers associated with our facility. It is our policy to provide a substitute health care provider, authorized by Santoro

Chiropractic P.C to provide assessment and /or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or any other health emergency.

**To Obtain Payment:** We may include your health information with an invoice used to collect payment for treatment you receive in this office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

**To Conduct Health Care Operations:** Your health information may be used in training programs for students, interns and associates. Some of our best teaching opportunities use clinical situations experienced by patients receiving care. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing and credentialing activities.

**Patient Communications:** We may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and curative care possible. As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office.

It is our practice to participate in charitable events to raise awareness, food donations, gifts, cards, money, etc. During these times, we may send you a letter, postcard, invitation or a phone call to invite you to participate in the charitable activity. We will provide you with the information about the type of activity, the dates of the activity. We will provide you with information about the activity, the dates and times. We will not disclose any personal information about your condition for the purpose of Santoro Chiropractic P.C. sponsoring fund raising events.

**Abuse or Neglect:** We will notify government authorities if we believe a patient is a victim abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

**Public Health and National Security:** We may be required to disclose to Federal Officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to control or prevention of an epidemic or the understanding of a new side effect of a drug treatment or medical device.

**Law Enforcement:** As permitted or required by state or federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report crime.

**Family, Friends or Care Givers:** We may share your health information with those you tell us will be helping with your home care, treatment, medications or payment. We will be sure to ask your permission first. In the event of an emergency, where you might be unable to communicate to us your wishes, we will use our very best judgment in sharing your health information only when it will be important to those in providing your care.

**Authorization to use or Disclose Health Information:** Other than is stated above or where Federal, State or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Chart # \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_\_

**Patient Rights: This law is careful to describe that you have the following rights related to your health information:**

1. **Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.
2. **Confidential Communications:** You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications,
3. **Inspect and Copy Your Health Information:** You have the right to read and review and copy your health information, including our complete chart, x-ray and billing record. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.
4. **Amend Your Health Information:** You have the right to ask us to update and modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with a written request and describe the reason for the change. Your request may be denied if the health information in question was not created by our office, is not part of our record or if the record containing your information are determined to be accurate and complete.
5. **Documentation of health:** You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations. Our documentation procedures will enable us to provide information from September 4, 2013. Please let us know in writing the time period for which you are interested. Thank you for limiting your request for no more than three years at a time. We may need to charge you a reasonable fee for your request.
6. **Request a Paper Copy of this Notice:** You have the right to obtain a copy of this notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information and to provide you this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to alter the terms of this notice. If we do, we will be sure all of our patients receive a copy of the revision. You have the right to express complaints to us or to the Secretary of Health and Human Services. If you believe your privacy rights have been compromised. We encourage you to express your concerns regarding your privacy of information. Please let us know your concerns or complaints in writing.

Santoro Chiropractic P.C. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy in respect to your personal information. If you have questions, please call 412-496-9403 for a personal conference.

**Complaints:** Complaints about your Privacy rights, acts, or how an employee has handled your health information should be directed to Dr. Santoro at 412-496-9403.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to

DHHS, Office of Civil Rights  
200 Independence Avenue S.W. Room 509F  
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Santoro Chiropractic P.C. with my authorization and consent to use and disclose my protected health information for the purpose of treatment and diagnosis.

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date