WELLNESS MONTANA

Pediatric Application for Care

Name _____ Birth Date ____ / ____ / ____ Sex ___ M ___ F Weight _____
Height _____ Parent(s)/Guardian(s) Name(s) _____
Address _____ City _____ State ____ Zip _____
Phone (H) _____ (C) _____ (W) _____
Email _____ Referred By _____

Purpose for Contacting Us _____
Other Doctors seen for this condition? Yes ___ No ___ If Yes, Name and Prior Treatments _____
_____
Other Health Conditions _____

Please check any of the following conditions your child has suffered in the last 6 months:

◯ Ear Infections	◯ Scoliosis	◯ Car Accident	◯ Temper Tantrums	◯ Growing/Back Pain
◯ Asthma	◯ Bed Wetting	◯ Difficulty Nursing	◯ Head Banging	◯ Headaches
◯ Colic	◯ Seizures	◯ Chronic Colds	◯ Sleeping Disorders	◯ Vision Problems
◯ Digestive Problems	◯ ADHD/ADD/Autism	◯ Recurring Fevers	◯ Constipation	◯ Tortecollis
◯ Flathead Syndrome	◯ Allergies	◯ Rashes	◯ Vaccine Reaction	◯ Diarrhea

Family History _____

Previous Chiropractor _____Date of Last Visit ___/___/___ Reason _____
Pediatrician _____ Date of Last Visit ___/___/___ Reason _____

Are you satisfied with the care that your child received there? Yes ___ No ___

Number of Antibiotic Doses Your Child Has Taken In the Last 6 Months _____ In Their Lifetime _____
Number of Other Prescription Medications Your Child Has Taken In the Last 6 months _____ In Their Lifetime _____

Vaccination History

◯ Flu/H1N1 (Prenatal)	◯ Rotavirus (2 mo)	◯ Rotavirus (4 mo)	◯ Pneu (12 mo)	◯ Hib (18 mo)
◯ HepB (Birth)	◯ HepB (2 mo)	◯ DTap (6 mo)	◯ MMR (12 mo)	◯ HepA (18 mo)
◯ DTap (2 mo)	◯ DTap (4 mo)	◯ Polio (6 mo)	◯ Varicella (15 mo)	◯ Flu/H1N1 (18 mo)
◯ Polio (2 mo)	◯ Polio (4 mo)	◯ Hib (6 mo)	◯ HepA (15 mo)	◯ Flu/H1N1 (2.5 yrs)
◯ Hib (2 mo)	◯ Hib (4 mo)	◯ Flu/H1N1 (6 mo)	◯ DTap (18 mo)	◯ DTap (4-6 yrs)
◯ Pneu (2 mo)	◯ Pneu (4 mo)	◯ Flu/H1N1 (7 mo)	◯ Polio (18 mo)	◯ Polio (4-6 yrs)
◯ MMR (4-6 yrs)	◯ Varicella (4-6 yrs)	◯ Flu/H1N1 (4-6 yrs)	◯ Tetanus	◯ Other

Prenatal History

Obstetrician/Midwife _____ Complications During Pregnancy _____
Induced Labor? Yes ___ No___ If Yes, How? _____ Doctor Assisted Labor? Yes ___ No___ If Yes, How? _____
Ultrasounds During Pregnancy? Yes ___ No ___ If Yes, How Many? ___ Medications during Pregnancy _____

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Cigarette/Alcohol Use During Pregnancy? Yes ___ No ___ Birthing Location: Home ___ Birth Center ___ Hospital ____
Birth Interventions: Forceps ____ Vacuum Extraction ____ Planned Caesarian Section ____ Emergency Caesarian ____
Delivery Complications? Yes ___ No ___ If Yes, Please List _____
Genetic Disorders? Yes ___ No____ If Yes, Please List _____
Birth Weight _____ Birth Length _____ APGAR Scores Immediately Following Birth _____ 5 Minutes _____

Feeding History
Breastfed? Yes ___ No ___ If Yes, How Long? _____ Formula? Yes ___ No ____ How Long? _____ What Type? ____
Solids introduced at _____ Months Cow's milk introduced at _____Months
Food/Juice allergies or intolerances? Yes ___ No____ If Yes, Please List _____

Developmental History
During infancy and childhood, your child's spine is vulnerable to stress and should be routinely checked by a chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age could your child:

Respond to Sound _____ Respond to Visual Stimuli _____ Hold Head Up _____ Sit Up Unassisted _____

Cross Crawl _____ Stand Alone _____ Walk Unassisted _____

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 stairs, etc.) Was this the case with your child? Yes ____ No ____

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) Yes ___ No____ If Yes, Please List _____
Has your child ever been involved in a car accident? Yes ___ No ___ If Yes, When? _____
Has your child been seen on an emergency basis? Yes ___ No ____ If Yes, Why and When? _____
Other Injuries/Traumas Not Listed Above _____
Prior Surgeries? Yes ___ No ____ If Yes, Please List _____
Menarche ? Yes ___ No ____ Age _____
Does your child have difficulty interacting with schoolmates or friends? Yes ___ No ____
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? Yes __ No__
What changes (if any) in your child's health or behavior would you like accomplished? _____
_____

Childhood Diseases

◯ Chicken Pox	Age _____	◯ Mumps	Age _____	◯ Rubella	Age _____
◯ Whooping Cough	Age ____	◯ Rubeola	Age _____	◯ Other _____	Age _____

We are here to serve you and answer questions. Your participation is vital and helps to determine your results.

Minor Consent
I, _____ being the parent or legal guardian of _____have read and fully understand the terms of acceptance and hereby grant permission for my child to receive Chiropractic Care.

_____ _____
Signature **Date**

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SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: **By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

Notice of Privacy Practices: **You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.**

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: **Deb Jacobs-Long 406-522-5433** Address: **8332 Huffine Lane Ste 5, Bozeman, MT 59718**

Right to Revoke: **You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

SIGNATURE **I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations and have received a copy of this Consent and Notice of Privacy Practices.**

Signature:_____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following: Personal Representative's Name: _____
Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.