Fitchett Chiropractic

FITCHETT CHIROPRACTIC PEDIATRIC HEALTH HISTORY FORM

Child's Name: _____ Age: _____ Birth Date: _____ Sex: M ☐ or ☐ F

Name of Parent(s)/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent Name & cell Number #1 : _____Parent name & cell Number #2: _____

E-mail Address: _____

How did you hear about our office?

_____

Reason for Visit: Wellness Check-Up ☐ Health Concern ☐

Please explain if health concern:

_____

Have you seen other doctors for this condition? Yes ☐ or ☐ No Who? _____

Type of Treatment: _____ Results: _____

Other Health Problems? _____

_____

Previous Chiropractor? _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

May we send a report updating your pediatrician?_____

Check any of the following that your CHILD has suffered from during the past 6 months:

☐ Ear Infections	☐ Asthma	☐ Headaches	☐ Car Accident
☐ Scoliosis	☐ Bed Wetting	☐ Neck/Back Pain	☐ Cold/Sinus
☐ Seizures	☐ Recurrent Fevers	☐ Colic	☐ ADD/ADHD
☐ Allergies	☐ Fatigue	☐ Temper Tantrums	☐ Digestive Problems

☐ Other _____

Has any other family member suffered from these symptoms? ☐ Yes ☐ No

Number of doses of antibiotics your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

Adverse reactions/allergies to any drug or vaccinations? ☐ No ☐ Yes

Explain: _____

Prenatal History:

Name of Obstetrician/Midwife: _____
Complications during pregnancy? _____ No _____ Yes – List: _____
Cigarette/Alcohol Use during pregnancy: _____ No _____ Yes

Location of Birth: _____ Hospital _____ Home _____ Birthing Center
Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Caesarian Section – Emergency or Planned? _____
Complication during delivery: _____ No _____ Yes – List: _____
Genetic Disorder or Disabilities: _____ No _____ Yes – List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely 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:

_____ Respond to Sound _____ Respond to Visual Stimuli _____ Hold Head Up
_____ Cross Crawl _____ Sit Up _____ Stand Alone _____ Walk Alone

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? _____ No _____ Yes

Is/was your child involved in any high impact or contact sports? _____ No _____ Yes
Sport(s): _____

Has your child ever been involved in a car accident? _____ No _____ Yes
List: _____

Has your child ever been seen on an emergency basis? _____ No _____ Yes
List: _____

Other Traumas not listed above? _____ No _____ Yes – List: _____
Prior Surgery? _____ No _____ Yes – List: _____
Menarche? _____ No _____ Yes – Age: _____

Childhood Diseases:

Chicken Pox: N/Y – Age: _____ Rubella: N/Y – Age: _____ Whooping Cough: N/Y – Age: _____
Mumps: N/Y – Age: _____ Rubeola/Measles: N/Y – Age: _____ Other: N/Y – Age: _____

Please list any areas of concern and provide details:

Upon completion of your child's first visit, you will receive a Chiropractic Report of findings. Chiropractic Treatment Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible.

CHIROPRACTIC CONSENT FOR CARE OF A MINOR

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and massage therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic associated with Fitchett Chiropractic, including the doctors at the clinic or office listed below or any other office or clinic associated with Fitchett Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the fact then known, is in my best interest. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, you condition could get worse, remain the same, or improve.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my condition.

_____ _____

Patient's Name (please print) Date Doctor's signature Date

_____

Signature of Patient or Legal Guardian & printed name, with relationship

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Fitchett Chiropractic Center (FCC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to FCC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. FCC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to FCC Privacy Officer, PO Box 207, Kennett Square, PA 19348.

With my consent, FCC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, FCC may send mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that FCC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to FCC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ I also authorize FCC to release PHI to:

Patient's Name (please print) Date

_____ _____

Signature of Patient or Legal Guardian Name Relationship

_____ _____

Print Name of Legal Guardian, if applicable Name Relationship