



PEDIATRIC HISTORY FORM APPLICATION FOR CARE AT FREEDOM CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Date of Birth: ____/____/____ Age: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone (Home): _____

Mother's Name: _____ Mother's Mobile: _____ DOB: ____/____/____

Father's Name: _____ Father's Mobile: _____ DOB: ____/____/____

Pediatrician/Family MD: _____ City & State: _____

Last Visit: ____/____/____ Reason for Visit: _____

Who is responsible for this bill? _____

CHILD'S CURRENT PROBLEM

Purpose of this visit:

Wellness Check-Up Injury or Accident Other (please explain): _____

If your child is experiencing Pain/Discomfort please identify where and for how long:

1. When did the problem first begin? Date: ____/____/____ Unknown Gradual Sudden

2. Ever had this problem before? No Yes If yes, when? _____

3. Any bowel or bladder problems since this problem began? If yes, describe: _____

4. Have you seen any other doctors for this problem? No Yes If yes, who? _____

5. How long ago? Days Weeks Months Years

6. What were the results of past treatment? _____

7. How is this problem NOW:

- Rapidly Improving
- Slowly Improving
- About the Same
- Gradually Worsening
- On & Off

8. Please list any medication taken for this problem:

9. Has your child ever sustained an injury playing organized sports? No Yes

If yes, please explain: _____

10. Has your child ever sustained an injury in an auto accident? No Yes

If yes, please explain: _____

HAS YOUR CHILD EVER SUFFERED FROM:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problem | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomachache | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Ear | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed/couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from highchair | <input type="checkbox"/> Fall of slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | |

Other: _____

OTHER MEDICAL HISTORY

1. Number of Antibiotics your child has taken in the last 6 months: _____

a) Total # of Antibiotics your child has taken: _____

2. Previous Chiropractic Care? Yes No If yes, previous Chiropractor: _____

a) Time under chiropractic care: _____

3. Complications during Birth? _____

Birth Interventions: Forceps Vacuum Extraction C Section

Other: _____

4. Feeding History: Breast Fed- How Long? _____ Formula-How long? _____

5. Food/ Drink Allergies or Intolerance? _____

6. According to the National Safety Council, 50% of children fall headfirst from a high place within their 1st year of life. Is this true with your child? _____

7. Other Trauma: _____

8. Is your child involved in high impact sports? No Yes If yes, what events?

9. Vaccination History: _____

SURGERIES/HOSPITALIZATIONS/ILLNESSES

Type: _____ Date: _____

Type: _____ Date: _____

Please list your child's daily activities and the length of time they do the activity:

Daily Activities

Homework: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Athletics: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Watching TV: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Sleep: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Computer Use: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Backpack Use: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Household Chores: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Reading: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

Yard work: Less than 1 hr. More than 1 hr. More than 2 hrs. More than 3 hrs.

ACTIVITIES OF DAILY LIVING

Please list any activities your child has difficulties with:

Activity 1: _____

Activity 2: _____

Activity 3: _____

MOTOR VEHICLE ACCIDENT HISTORY

1. When was your child's most recent auto accident: _____

a. Speed: _____

b. Front, side or rear-end collision? _____

c. Was treatment received? No Yes If yes, where? _____

2. Is there any other injury to your child's spine, minor or major, that the doctor should know about?

FAMILY HISTORY

Have you or anyone in your child's **IMMEDIATE** family had any of the following conditions:

Heart Disease	Stroke	Diabetes	Alzheimer's
Cancer	Heart Attack	Mental Illness	Learning Disability
High/Low Blood Pressure	Arthritis	Spine Problems	Epilepsy
Anemia	Liver Trouble	Digestive Problems	Kidney Trouble
Chest Pain	Asthma	Other:	Other:

FINANCIAL RESPONSIBILIITY

I understand that I am directly and fully responsible to Freedom Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (PAGE 1)

WELCOME. We are honored to be part of your journey to better health. Please read these policies and consent carefully. We feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. If you have questions or anything is unclear, please let a member of our staff know before submitting your **Application for Care**. It is in everyone's best interest that your decision as to whether you wish to become a patient is informed. Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

FIRST THINGS FIRST: Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

CHIROPRACTIC CARE: When a patient seeks chiropractic care, it is essential that the patient and doctor are working toward the same objective. Chiropractic is a branch of the healing arts distinct from other branches (e.g. osteopathic or allopathic). Doctors of chiropractic view health as a continuum from optimal health, to hidden imbalances, to disease. Rather than treating disease, chiropractic aims to improve health by eliminating underlying imbalances that interfere with the body's functioning. Such imbalances include subluxation, a major interference to the expression of the body's innate wisdom. Our doctors use specific spinal correction and musculoskeletal techniques to help eliminate subluxation. We also use diagnostic testing and nutritional remedial measures to help achieve homeostasis - a dynamic equilibrium, in which the body continuously changes to maintain optimal internal stability in response to external conditions. As doctors of chiropractic, we do not prescribe drugs or perform surgery and all changes to prescription medications must be made by your prescribing provider. We may, however, recommend homeopathic and botanical medicines, vitamins, minerals, phytonutrients, antioxidants, enzymes, glandular extracts, non-prescription drugs, and medical goods and devices. Although we may screen for the prevention and early detection of cancer, doctors of chiropractic do not treat cancer. We may, however, work with patients who have cancer in conjunction with, but not replacing, drugs, surgery, or chemotherapy. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

RISKS: Chiropractic adjustment involves some risk including, without limit, fractures, disc injury, sprains, dislocation, and vascular injuries/stroke. Hidden conditions, such as tumors and vascular disorders, may increase this risk. Although the nutritional remedial measures we recommend are generally considered safe, they involve some risk including, without limit, changes in blood sugar, allergic reaction, and gastrointestinal upset. They may also be inappropriate during pregnancy, toxic in large doses, and may interact with certain drugs. You agree to consult with your prescribing physician/provider about any prescription drugs you are taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. You also agree to immediately report suspected pregnancy or any potential interactions to us and your prescribing providers.

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (PAGE 2)

ALTERNATIVES: I understand that the alternatives include doing nothing and/or relying solely on care from providers in other branches of the healing arts. We always encourage you to communicate with your other health providers about your care.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for products purchased or services rendered.

I hereby authorize payment to be made directly to Freedom Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Freedom Chiropractic for any and all services I receive at this office.

PATIENT PRIVACY: The majority of care takes place in an open bay area. Accordingly, conversations you have with the doctor may be overheard by others. To maintain privacy, if you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

REPORT OF FINDINGS: To enhance understanding of our approach, you will be scheduled for a "Report of Findings" following your first appointment. Attendance is required for individuals who wish to become patients of this practice. Because the results of your examinations and care recommendations will be discussed at that time, we strongly urge you to invite your spouse or a significant other to attend. We know that when a patient's family understands the goals of care and how restoring and maintaining health can affect their lives as well, they become supportive in making important treatment decisions.

QUESTIONS AND ANSWERS: I have read and fully understand this consent and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words. Knowing the risks of chiropractic care, I consent to chiropractic care and recommendations.

EMAILS: I understand that by providing my email address, I authorize Freedom Chiropractic to send me emails.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!

Note: Patient retains the above Notice of Office Policies and Freedom Chiropractic retains the signature sheet.

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (PAGE 3)

Patient initials: _____-retaining pages 1 & 2 of 3

I hereby acknowledge receiving a copy of the practices 'Freedom Chiropractic Policies & Consent to Care' a three page document, the first two pages of which I have read and retained. This third page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Name (Print)

DOB

Patient Signature

Date

FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (PAGE 1)

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner, and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive “Detail Privacy Notice”.
3. To request mailings to an address different that residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Jason Cahill, D.C. at (719) 533-0303.

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

DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (PAGE 2)

Patient initials: _____-retaining page 1 of 2

Freedom Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of Freedom Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name (Print)

DOB

Patient Signature

Date

HIPAA CONSENT FORM

Freedom Chiropractic is committed to insuring the privacy and confidentiality for your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

To whom may we speak with other than yourself regarding your medical care?
(If more than one, please list all)

- Spouse Child Sibling Care Giver Friend Other

Name: _____ Phone: _____

- Spouse Child Sibling Care Giver Friend Other

Name: _____ Phone: _____

- Spouse Child Sibling Care Giver Friend Other

Name: _____ Phone: _____

May we leave a voicemail on your primary phone number? Yes No

May we leave a voicemail on your work phone number? Yes No

May we leave a voicemail on your alternate phone number? Yes No

May we mail medical information to your home? Yes No

I have been made aware of the privacy policies of Freedom Chiropractic, and have received (or made available to me) a copy of the Notice of Privacy Practices of Freedom Chiropractic.

Patient Signature

Date