PEDIATRIC NEW PATIENT INFORMATION

PATIENT INFORMATION

Child's Name ____________________

Parent(s)/Guardian(s) ____________________

Address ____________________ City/State/Zip ____________________

Home Phone __________ Work Phone __________ Cell Phone __________

Is it okay to contact you at work? ❑Yes ❑No

E-mail ____________________

Child's Birth date __________ Age ______ Weight ______ Height ______

Date of your child's last Chiropractic Adjustment ? __________

How did you find out about our office?

____

Is your child receiving care from other health professionals? ❑Yes ❑No If yes, please provide name & specialty

____

Please list any medications your child is currently taking

____

Please list any vitamins/herbs/homeopathics/other your child is currently taking

____

Allergies? ____________________

Favorite Hobbies/Activities

____

Current Health

Is there a health condition that brings your child to our office? ____________________

____

When did the symptoms first begin? ____________________

Did the problem start: ❑Suddenly ❑Gradually ❑ Post-Injury

Is this condition ❑Getting Worse ❑Improving ❑Intermittent ❑Constant ❑Not Sure

What makes the problem better and/or worse?

____

____

Has your child ever had a similar condition? ❑Yes ❑No

Has your child been treated for this problem before? ❑Yes ❑No

Does your child eat well? ❑Yes ❑No Does your child have regular bowel/bladder movements? ❑Yes ❑No

Has your child ever been checked for vertebral Subluxations? ❑Yes ❑No ❑Don't Know

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HEALTH HISTORY

Child's birth was ❑Natural vaginal (no medications/interventions) ❑ Vaginal with interventions ❑ Induction ❑Pain medication ❑Epidural ❑Episiotomy ❑Vacuum extraction ❑Forceps ❑C-section ❑ Scheduled ❑Emergency ❑ Other ______________

Please explain any interventions/complications____

Child's birth weight______ Child's birth height______APGAR score at birth______APGAR score (5 min)______

At what age did your child: Respond to sound ____ Follow an object ____ Hold head up ____ Vocalize ____

Sit alone_____ Teethe ____ Crawl _____ Walk_____

Hospitalizations/Surgical history:____

____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:

____

Is/was your child breastfed? ❑Yes ❑No If yes, how long?_________________If not, please explain:____________

____

Formula introduced at age____ What type? ____

Introduction of cow's milk at age ____ Began solid foods at age____ Any difficulty with bonding? ❑Yes ❑No

Did mother smoke during pregnancy? ❑Yes ❑No Did mother drink alcohol during pregnancy? ❑Yes ❑No

Any illness of mother during pregnancy? ❑Yes ❑No If yes, please explain_________________________________

List any drugs/medications (including over the counter)/supplements taken during pregnancy

____

____

Has your child ever had: ❑Vision Problems ❑Headaches ❑Breathing problems/Asthma ❑ADD/ADHD ❑Ear Aches/infections ❑Frequent Colds ❑Colic ❑Digestive Problems ❑Bed Wetting ❑Mobility Issues

Has your child received any vaccinations? ❑Yes ❑No If yes, which ones?_________________________________

____

Has child received any antibiotics? ❑Yes ❑No If yes, how many times and why?_____________________________

____

Any behavioral problems? ❑Yes ❑No Please explain____

____

Any night terrors, sleepwalking or difficulty sleeping? ❑Yes ❑No

Does your child seem "normal" for their age? ❑Yes ❑No Please explain_________________________________

____

The above information is true and accurate to the best of my knowledge. I authorize NCWC to render necessary services to my child and understand that I am responsible for all charges incurred.

Parent/Guardian Signature ____ **Date** ________________

CONSENT OF MINOR

I, being the parent or legal guardian, hereby authorize Dr. Bjorn Bostrom and whomever he may designate as assistant to administer treatment and procedures as deemed necessary to my son/daughter/ward in my custody. The doctor has no implied guarantee of cure.

______________________________ Name of Minor

_____/_____/_____ Date of birth

Parent or Guardian's Name (please print): ______________________________

Parent of Guardian's Signature: ______________________________

Relationship to Minor: ______________________________

Date: ______________________________

Informed Consent for Chiropractic Care

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays) if needed.

Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by subluxation.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. T chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.

By signing below, you acknowledge that you have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments will be explained, including the risks, consequences and probable effectiveness of each, upon request. You will be advised of the possible consequences if no care is received. This office makes no guarantees concerning the results of the care and treatment that we offer.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I WILLINGLY AUTHORIZE NETWORK CHIROPRACTIC WELLNESS CENTER & BJORN BOSTROM, DC TO PROCEED WITH CHIROPRACTIC EXAMINATION AND CARE.

____
Print Patient Name

____
Date

____
Patient Signature

____
Doctor Signature

Parental Consent for Minor Patient

I give permission for the above named minor patient to be managed by the doctor, in and/or out of my presence.

____
Signature

____
Relationship to Patient

Patient Privacy

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Network Chiropractic Wellness Center (NCWC) will not use or disclose protected health information without a valid authorization form, except as permitted or required by the HIPAA rule. When NCWC obtains or receives a valid authorization form for use or disclosure of protected health information, such use or disclosure will be restricted to that which is the minimum necessary to accomplish the purpose described in the authorization form. Each authorization form has to be specific to the release under consideration. The specific requirements for authorizations are outlined below.

1. Return all authorizations known to be defective to the party requesting the information with an explanation of why the requested information is not being disclosed, or
2. Have the patient review the defective authorization and have the patient read and sign a new authorization form before releasing the health information.
3. A description of each purpose of the requested use or disclosure. The statement, “at the request of the individual,” is a sufficient description of the purpose when an individual does not desire to make an explanation.
4. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.
5. Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative’s authority to act for the individual must also be provided.

The authorization form must contain statements adequate to place the individual on notice of all of the following:

- The individual’s right to revoke the authorization in writing; and
- The potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by this regulation.

The covered entity must provide the individual with a copy of the signed authorization.
A valid authorization may also contain elements or information in addition to these required elements, provided that such additional information is not inconsistent with the required elements stated above.
If the individual refuses to sign the authorization form, the covered entity cannot condition treatment on failure to obtain such authorization
A covered entity may not use or disclose protected health information to a requesting party if the authorization is defective. A defective authorization is one that has expired, is incomplete, has been revoked, or is known to be false.

Print Patient Name ______________________ Date ______________________

Patient Signature ______________________

INSURANCE WAIVER

Due to constant changes in health insurance policies, patient self-billing has become a cost effective way for you, the patient, to get the maximum reimbursement for your care. Furthermore, patient self-billing allows us to keep our fees low so you can get the care you need without any added cost. Our office policy is that all payment is due at the time of service.

By signing below, you acknowledge that insurance claims will not be sent to your insurance provider by our staff. However, we will provide you with a monthly statement of care which you may submit to your insurance provider. As each insurance company, policy and plan is different, we can not guarantee reimbursement and are not responsible for your policy's chiropractic coverage.

____
Print Name

____
Signature

____
Date