7703 Brodie Ln, #C, Austin, TX 78745
(512) 529-1002
transformaustinhealth@gmail.com
www.transformaustinhealth.com

Transform Austin Chiropractic
Child Health History

Name:	Preferred Name:	Today's Date:
Street Address:		
Mailing Address (if different):		
Date of Birth:	Height:	Weight:
Parent Name:	Phone Number:	
Child's grade and school:	Emergency contact:	

Please describe the special qualities and/or unique attributes of your child: _____
_____

Please describe their current symptoms or health concerns: _____
_____

List all their current activities/sports: _____
_____

Information about ***their*** birth:

Location: ☐Hospital ☐Birth Center ☐Home ☐Other:	
Birth Attendant(s): ☐OB ☐Midwife ☐Family Doctor ☐Doula ☐Other:	
Type of birth: ☐Vaginal ☐C-section (was C-section: ☐elective ☐emergency ☐neither)	
Interventions (check all that apply): ☐Induction with ptocin ☐Vacuum extraction ☐Use of forceps	
☐Long Labor (24+ hours) ☐Difficult labor ☐Epidural ☐Narcotics ☐IV drugs ☐Other:	
Was there maternal drinking, smoking, or drug use (prescription or otherwise) while pregnant: ☐Y ☐N	Were they born: ☐Prematurely ☐Late (42+ weeks) Number of weeks gestation at birth:
Any other complications with their mother's pregnancy or your birth?	
Were they hospitalized for any medical reason after birth?	
Were they breastfed? ☐ Yes ☐No If yes, for how long?	

Medications, and Supplements:

Please list all medications/drugs they have taken in the past 6 months and why: _____
_____
_____

List all vitamins/herbs/supplements they are taking and why: _____
_____
_____

General Health History:

Please list all past surgeries (emergency, elective, dental, etc.)

1. Type:	When?	Doctor:
2. Type:	When?	Doctor:

Have you had any major accidents or injuries? (falls, auto accidents, work-related injuries, broken bones)

1.Type:	When?	Hospitalized? ☐ Yes ☐ No
2.Type:	When?	Hospitalized? ☐ Yes ☐ No

How often does your child "get sick"? ☐ Once a week ☐ Once a month ☐ Once a quarter ☐ Less
When your child "gets sick" do you use: ☐ Antibiotics ☐ Homeopathy ☐ Herbs ☐ Tylenol or similar ☐ Other: _____

Has your child been vaccinated? ☐ Yes ☐ No
If yes, ☐ Full ☐ Partially ☐ Alternative Schedule

Please mark all the following conditions your child have had or have now (- have had / + have now)

☐ Congestion	☐ Allergies	☐ Anemia
☐ Frequent Bruising	☐ Frequent Falls	☐ Night Terrors
☐ Diabetes	☐ Diarrhea	☐ Eczema
☐ Depression	☐ Heahaches	☐ Heart Disease
☐ Irregular Periods	☐ Low Blood Sugar	☐ Chicken Pox
☐ Delayed Speech	☐ High Blood Sugar	☐ Mumps
☐ Thyroid Problems	☐ Pneumonia	☐ Colic
☐ Speech Problems	☐ Ear Infections	☐ Asthma
☐ Constipation	☐ Convulsions	☐ Broken Bones
☐ Skin Conditions	☐ Epilepsy	☐ ADD/ADHD
☐ Late to Walk	☐ Croup	☐ Antibiotic Use
☐ Late to Crawl	☐ Menstrual Cramps	☐ Migraines
☐ Neck/Back Pain	☐ Nervousness	☐ Tantrums
☐ Teeth Problems	☐ Measles	☐ Sinus Problems

Are there any other health concerns or conditions that your child has now or has had that we should know about: _____

_____

I consent to a professional and complete chiropractic examination that Dr. Stephanie deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Printed Name of Guardian: _____

Relationship to Child: _____

Guardian Signature: _____ Date: _____

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Activities of Daily Living

To properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1.	Static Sitting	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
2.	Sleeping	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
3.	Personal Care (washing, Dressing, etc.)	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
4.	Travel (driving, etc.)	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
5.	Work	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
6.	Recreation	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
7.	Household Chores (Vacuuming, Cleaning, Etc.)	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
8.	Lifting	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
9.	Walking	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
10.	Standing	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain

Patient's Signature: _____ Today's Date: _____

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INFORMED CONSENT

This office practices evidence based spinal care. This practice is based on nationally recognized practice guidelines as well as published research conducted at numerous universities and chiropractic colleges. Our commitment to you is to deliver the safest, highest quality of life changing care we can deliver focused on the reduction of spinal cord tension, spinal subluxations and to develop and maintain spinal and neural integrity.

To begin care, we need your consent to perform a history and physical evaluation focused on testing procedures and questions that solely relate to quality of life, stress levels, body awareness, spinal cord tension, spinal subluxations and the loss of spinal and neural integrity. The intent of your evaluation is to assess your current level of spinal and neural integrity. From there we will be able to create a plan to maximize your quality of life and degree of well being.

We will not be performing a differential diagnosis to detect the presence of or determine target treatment for any disease, condition or symptom. The only diagnosis we will provide is that of spinal subluxation. If you desire advice, diagnosis or treatment for any symptom, condition, disease or concern we recommend that you seek the services of a health care provider who specializes in that area.

I (print name) _____ have read and fully understand the above statements. I understand that the spinal adjustments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom other than spinal tension, vertebral subluxation and the associated loss of spinal and nerve system integrity. This office offers chiropractic as a form of health and wellness care, to promote the natural mechanisms for self healing and empowerment, as compared to targeting a specific area of treatment. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

Permission to approve consent for a minor: (Print Child's name for which you give consent):

_____ Parent/guardian Signature: _____

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Notice of Privacy Practices

This Notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information has always been important to us and we are committed to protecting it. New federal laws, however, require that we provide each of our patients with an official notice of our privacy practices. This notice will inform you of ways we use and share your information and it will describe your rights and our duties regarding the use and disclosure of health information.

Law requires us to:

- Keep your health information private
- Give you this Notice of Privacy Practices
- Abide by the terms of the Notice of Privacy Practices currently in effect

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that law permits the changes. If we make changes, we will update this notice and make the new notice available upon request.

Listed here are some of the ways we may use or disclose your information without your specific consent or authorization. Not all possible uses or disclosures are listed.

For Treatment: We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share health information about you with your other health care providers to assist them in treating you.

For Payment: We may use and disclose your health information for payment purposes.

For Health Care Operations: We may use and disclose your health information for our health care operations. For example, we may use health information about you to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Possible Uses and Disclosures:

- In response to a legal proceeding
- For other healthcare provider's treatment activities
- For other covered entities and provider's payment activities
- In case of threat to public health or safety
- To notify a family member in certain emergency situations
- To workers' compensation or similar programs for processing of claims
- In domestic violence or neglect situations
- Other uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

The health and billing records we create are the property of this healthcare facility. The health information in it, however, generally belongs to you.

You have the right to do the following:

- Request and receive from us a copy of the most current Notice of Privacy Practices.
- Look at or receive copies of your health information. You may make this request in writing and we have a form available for that purpose. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request.
- Ask us to restrict certain uses and disclosures. You must submit this request in writing. We are not required to grant the request but will comply with any request granted.
- Have us review a denial of access to your health information -- except in certain circumstances.

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- Ask us to change your health care information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of records.
- Request a list of disclosures of your health information. The list will not include disclosures to third party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by other means or at another location. Please sign, date and give us your request in writing. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.
- Cancel a prior authorization to use or disclose health information by giving us a written revocation. Your revocation does not affect any information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Open or Group Adjusting Authorization Request: You will receive chiropractic adjustments in a room where other clients are also receiving chiropractic care. In the course of your care in such an environment, routine details of your condition and care may be disclosed to other clients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other clients. However, we can offer you the opportunity to discuss your health care in a more private setting at your request.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with all of the methods and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future, please advise us accordingly in writing.

Photographs and Testimonials: From time to time, we have our practice members write out or verbally share their experience with care, to share with other practice members. We may take photos of all of the kids in the practice in celebration of health and wellness, and display them on the wall. We are requesting your authorization for this matter.

We may also have sign-up sheets posted at the front desk for email lists or health class sign-up sheets (and the like).

If you have questions or wish to report a problem, you may contact the Texas State Privacy Officer at (512) 776-6502 or hippa.privacy@dshs.texas.gov.

If you believe you privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a complaint with the State of Colorado Privacy Officer, or with the U.S. Secretary of Health and Human Services. All complaints must be in writing. You will not be penalized or discriminated against for filing a complaint.

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Consent of Privacy Statement

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received copy of Transform Austin's Notice of Privacy Practices.

_____
Print Patient Name Date

_____
Patient Signature Date

If signing for a minor child:

_____
Printed Name of Guardian

_____
Description of Guardian

_____
Guardian Signature Date