CONFIDENTIAL PATIENT INFORMATION - Pediatric (12 and Under)

ABSOLUTE Wellness

Patient's Name _____ SSN _____ Date _____
Home Phone _____ Cell Phone (Parent) _____
Address _____ City _____ State _____ Zip _____
Sex □ M □ F Birthdate _____ Age _____ Current Height _____ Current Weight _____
Has your child had chiropractic care previously? □ No □ Yes When _____ Doctor's Name _____

Parent/Guardian Name _____ SSN _____
Email Address _____
Occupation _____ Employer _____
Work Address _____ Work Phone _____
Home Address (if different than child) _____ City _____ State _____ Zip _____
Who may we thank for referring you? _____
Would you like to receive reminders? □ Text □ Email Cellular Carrier _____

Parent/Guardian Name _____ SSN _____
Email Address _____
Occupation _____ Employer _____
Work Address _____ Work Phone _____
Home Address (if different than child) _____ City _____ State _____ Zip _____
Who may we thank for referring you? _____
Would you like to receive reminders? □ Text □ Email Cellular Carrier _____

If your child has a specific injury or condition you would like to have evaluated, please describe below.
If you are seeking a Well Baby Check Up or Preventative Child Evaluation, please go to page 3.

	PRIMARY CONCERN	SECONDARY CONCERN
Please describe concerns and symptoms that are causing you to seek treatment.	_____ _____	_____ _____
When did symptoms start?		
Have you had these symptoms previously?	□ Yes, when? _____ □ No	□ Yes, when? _____ □ No
The pain is...	□ Constant □ Comes and Goes	□ Constant □ Comes and Goes
What makes the pain better?		
What makes the pain worse?		
Have you missed any work/ school due to this complaint?	□ Yes □ No	□ Yes □ No
Is this issue the result of an automobile accident? Explain.	□ Automobile Accident _____ _____	□ Automobile Accident _____ _____
Have you received any other treatment for this issue? What type?	□ Chiropractic □ Physical Therapy □ Surgery □ Other_____ Physician's Name _____	□ Chiropractic □ Physical Therapy □ Surgery □ Other_____ Physician's Name _____
Doctor's Notes		

Traumas Please list traumas your child has experienced in life. (auto accidents, major falls, birth traumas, etc.)

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Surgery Please list any surgeries your child has had and the date of the surgery.

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Medication Please list all medications your child is currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Number of doses of antibiotics your child has taken…
During the last 6 months _____ During his/her lifetime _____

Nutrients Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Family History Insert ages and check any box that applies.

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other												

Doctor's Use Only _____

_____

Childhood Diseases

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

Please circle the following conditions your child has suffered from during the past six months.

ADHD	Asthma/Allergies	Autism	Bed Wetting
Chronic Colds	Colic	Digestive Problems	Ear Aches
Growing Pains	Headaches	Recurring Fevers	Scoliosis
Seizures	Temper Tantrums	Other _____	_____

Lifestyle Lifestyle, diet and exercise habits play an extremely important role in overall health and risk of chronic disease. The following questions are designed to help us understand your habits and your desires as well as commitments to make changes to those habits if necessary.

Prenatal History

1. Did the child's mother receive chiropractic care during pregnancy? N Y Frequency _____
2. Were there any complications during pregnancy? N Y
   If yes, please explain. _____
3. Were any ultrasounds performed during the pregnancy? N Y How many? _____
4. Was any medication taken during pregnancy? N Y
   If yes, please list. _____
5. Was any medication taken during delivery? N Y
   If yes, please list. _____
6. Was there any use of cigarettes or alcohol by the mother during pregnancy? N Y
7. Where was the child born? □ Home □ Birthing Center □ Hospital
8. How was the child delivered? □ Vaginal Birth □ Planned C-Section □ Emergency C-Section
9. How was the child presented? □ Head First □ Breech □ Transverse Lie
10. If intervention was used during the birth, what type? □ Forceps □ Vacuum Extraction
11. Were there any complications during delivery? N Y
    If yes, please explain. _____
12. Was the child born with any genetic disorders or disabilities? N Y
    If yes, please explain. _____
13. Birth Weight _____ Birth Length _____ APGAR Scores _____

Diet

1. Was the child breastfed? N Y How long? _____
2. Was the child formula fed? N Y How long? _____ What kind? _____
3. When was the child introduced to… Solid Foods _____months Cow's Milk _____months
4. Does the child have any know food/juice allergies or intolerances? N Y
   If yes, please list. _____
5. How may servings of fruits and vegetables does the child eat per day? 0 1 2 3 4 5 6 7 8 9 10
   (2-3yrs old: 1/4-1/2 cup=1 serving) (4-12yrs old: 1/2-1 cup=1 serving)

Vaccine History

1. Has the child received vaccinations? N Y
   □ All Recommended by Pediatrician □ Some Vaccinations □ No Vaccinations
2. Has the child has any adverse reactions to any vaccines? N Y
   If yes, please explain. _____

Physicians

Pediatrician/PCP's Name _____ Phone Number _____
Address _____ City _____ State ____ Zip_____

Obstetrician/Midwife's Name _____ Phone Number _____
Address _____ City _____ State ____ Zip_____

□ Check here if you do NOT authorize this office to communicate with my primary physician about the care I receive.

Parent's Name Printed _____ Signature _____ Date _____

I verify that the information I have provided in this document is true and I give the doctor consent to treat the child.

Patient's Name Printed _____ Date of Birth _____

Parent/Guardian's Name Printed _____ Date _____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____, as the parent/guardian of _____
(name of parent/guardian) (name of minor/child being treated)

hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of the child's protected health information (PHI) necessary for the practice to provide analysis and treatment for the child, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
Postcards mailed to the addresses I have provided. Emails to the addresses I have provided.
Calling, texting, leaving messages at the numbers I have provided or with the individual answering the phone.

____ 4. The practice may use and/or disclose the child's PHI (which includes information about my health or condition, analysis, and the treatment provided) in order for the practice to make analyses about the child's condition(s), treat the child, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as the child is a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

____ 7. I give Absolute Wellness permission to treat the child in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of the child's protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations

____ 8. The doctor recommends that my spouse/partner/caretaker/guardian be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse/partner/caretaker/guardian contacts the office to check on my status.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat the child.

Patient's Name Printed _____ Date of Birth _____
Parent/Guardian's Signature _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that the parents/guardians of the child understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at www.chiropracticpeoria.net.

I have read and understand the information above.

Patient's Name Printed _____ Date of Birth _____
Parent/Guardian's Signature _____ Date _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release any information deemed appropriate concerning the child's health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges occurred at this office.

I authorize and assign the direct payment to you of any sum owed on behalf of the child now or hereafter to your office by my attorney out of the proceeds of any settlement of the case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.

I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.

In the event any insurance company under contractual agreement refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in the child's favor against any such company and authorize you to prosecute said action either in the child's name or your name as you see fit. I further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Patient's Name Printed _____ Date of Birth _____
Parent/Guardian's Signature _____ Date _____