

PEDIATRIC HISTORY

Date _____

Name (first) _____ (mi) _____ (last) _____

Mailing Address _____ City _____ State _____ Zip _____

Gender Male Female Birthdate(mm/dd/yyyy) _____ Age _____ SSN _____

Parent/ Guardian Name _____

Parent/Guardian Name _____

Home Phone # _____ Parent 1 Work ph# _____ Parent 2 Work ph# _____

Email Address: _____

Birth Weight _____ Current Weight _____ Birth Length _____ Current Length/Height _____

Siblings Names & Ages _____

Referred to our Office by _____

Purpose for contacting us _____

Other Chiropractors seen for this concern _____

Date of last visit _____ Reason for visit _____

Other Doctors seen for this concern _____

Date of last visit _____ Reason for visit _____

Name of Pediatrician _____

Date of last visit _____ Reason for visit _____

Other health concerns? _____

Check any of the following conditions that may apply to your child:

- Ear Infections Scoliosis Seizures Chronic Colds Digestive Problems
 Headaches Asthma/Allergies Colic Recurring Fever Growing/Back Pains
 Car Accident Bed Wetting ADHD Temper Tantrums Other _____

Number of Rounds of **Antibiotics** your child has taken:

In the last 6 months _____ Total during lifespan _____

Number of Rounds of **Other Prescription Medications** your child has taken:

In the last 6 months _____ Total during lifespan _____

Has your child received vaccinations? No Yes If yes, please list vaccines & dates _____

Prenatal History:

Conception: Natural IUI IVF Fertility Drugs Donor Egg/Sperm Surrogate Adoption

Name of Obstetrician/Midwife _____ Location of birth: Home Birth Center Hospital

Complications during pregnancy? No Yes If yes, please list _____

Ultrasound exams during pregnancy? No Yes If yes, how many? _____

Birth Interventions:

Induction Artificial rupture of membranes Forceps Vacuum extraction C-section, ER or planned?

Complications during Labor/Delivery? No Yes If yes, please list _____

Genetic Disorders/Anomalies? No Yes If yes, please list _____

Medications during pregnancy? No Yes If yes, please list _____

Cigarette/Alcohol use during pregnancy? No Yes If yes, please describe _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting Dr. Jennifer Anacker.

Please list the individual(s) with whom we are able to share your health information with, such as children, parents, or spouse.

Name: _____ Relationship to you: _____

Your name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including diagnostic x-rays (if needed), and any supportive therapies on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts them known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment from my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Name Printed of Guardian/Parental and Relationship to Patient:

Guardian/Parental Signature: _____