PEDIATRIC HISTORY

Date_____

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

Feeding History: Breast fed? □No □Yes How long? _____ Formula fed? □No □Yes How long? _____
Introduced to solid food at what age? _____; Cow's milk at what age? _____
Food/juice allergies/intolerances □No □Yes If yes, please list_____
Oral Ties? □ Tongue □ Lip □ Buccal Has it been revised? □No □Yes
If yes, when and list provider _____

Habits	**Amount & Frequency**
___ Dairy	_____
___ NutraSweet(aspartame)	_____
___ Soda Pop (reg./diet)	_____
___ Coffee	_____
___ Snoring	_____
___ Clenching/Grinding teeth	_____

___ Carries heavy bag/backpack □ R. side □ L. side Sleep posture □Right side □Left side □Back □Stomach

Developmental History: During the following milestones of development, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation and spinal nerve interference.

At what age was your child able to: ____Respond to sound ____Respond to visual stimuli(3+mos.)
____Hold head up(5-6mos.) ____Sit-up(9-10mos.) ____Cross Crawl ____Stand Alone ____Walk alone

According to the National Safety Council, approximately 50% of children fall headfirst from a high place during their first year of life (i.e. from a bed, changing table, down the stairs, etc.) Is this the case with your child? □No □Yes

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, basketball, baseball, cheerleading, martial arts, etc.)? □No □Yes If yes, please list_____
Has your child ever been in a car accident? □No □Yes If yes, please list_____
Has your child ever been seen on an emergency basis? □No □Yes If yes, please list_____
Prior surgeries? □No □Yes If yes, please list_____
Date of first menstrual cycle (if applicable) _____

Childhood Diseases:

Chicken Pox □No □Yes Age_____ Mumps □No □Yes Age_____ Rubeola (Measles) □No □Yes Age_____

Whoop. Cough □No □Yes Age___ Rubella (German Measles) □No □Yes Age____ Other _____ Age____

Health Attitudes:

____***Treatment Only*** – I consult a doctor when I or my child have aches/pain and discontinue upon it's clearing up.

____***Prevention*** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

____***Maintaining health*** – I'm conscious about my health, diet, exercise, etc. and actively pursue these in order that I and my family feel better, perform better, and it maximizes each of our potential.

____***Family health*** – I take an active part in assisting and maintaining health with my family. I'm concerned with long term effects of good health and wellness.

<u>Authorization for Care of Minor</u>

I hereby authorize this office and its Doctors to administer care as they deem necessary to my son/daughter.

_____ _____ _____
Parent/Legal guardian signature Witnessed by Date

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: _____

Name Printed of Guardian/Parental and Relationship to Patient:

_____

Guardian/Parental Signature: _____