Vitality Wellness Chiropractic

Pediatric Form

PERSONAL INFORMATION

Date:		
Name (Legal):		**Preferred Name:**
Address:		
City/State/Zip:		
E-mail:		
Mother's Name:	**Father's Name:**	
Mother's Phone: ( )	**Father's Phone: ( )**	
Date of Birth:	**Age:**	**Sex: M F**
Current Height:	**Current Weight:**	
Person Financially Responsible for Account:		**Parent/Guardian**
Name of person(s) we can discuss care/account with (name/relationship):		
Have you seen a chiropractor before? (circle one) YES NO	**Doctor's Name:**	
What are the goals you hope your child will gain?		

PRENATAL CARE

Were there any complications or unusual stressors during pregnancy?
Medications during pregnancy?
Cigarette/Alcohol use during pregnancy?
Third Trimester Presentation (circle one) Breech Transverse Face/Brow Vertex

PREGNANCY HISTORY

Was the delivery premature or full-term?	**Gestational Age:**
Was the delivery via C-section or vaginal?	
Was the delivery an emergency?	
Was medication given to induce labor?	
Were forceps used in the delivery?	**Vacuum Extraction?**
Were there any other complications during Labor or Delivery?	
Were there any emotional stressors on the mother during Labor/Delivery?	
Was there a presence of: Jaundice (yellow) Cyanosis (blue) Congenital Anomalies/Defects?	

If yes, please explain:
Birth weight: **Length:**
APGAR Scores: At one minute? **At five minutes?**
Did your child require additional hospitalization?

INFANT HISTORY

Infant feeding (circle one): Breast Bottle
Did your child have any difficulty latching on or any sucking difficulties?
Number of hours of sleep per night: **Quality of sleep (circle one): Good Fair Poor**
Has your child ever been hospitalized? **If yes, please explain:**
Has your child ever had any surgeries? **If yes, please explain:**
Is your child currently on any medications? **If yes, please list:**
Does your child have any allergies? **If yes, please list:**

DEVELOPMENTAL HISTORY

Please tell us about your child's development? Did they show any signs of delay or advancement?
Does your child tend to fall frequently?
Is/has your child been involved in any high impact or contact type of sports (e.g., soccer, football, martial arts, gymnastics, etc.)?
Has your child ever sustained an injury playing sports or from falls?
Has your child ever been involved in a car accident?

CHILD'S CURRENT PROBLEM

Purpose of this visit:
Onset of problem?
Has the child had this problem before? **If yes, when?**
Any bladder or bowel problems since this problem began?
Have you seen any other doctors for this problem?

Please indicate if your child or a family member has had any of the following:
Mark "C" for child, "F" for family member

____ Alcoholism
____ Anemia
____ Appendicitis
____ Arteriosclerosis
____ Asthma
____ Cancer
____ Chicken Pox
____Cold Sores
____ Diabetes
____ Eczema
____ Emphysema
____ Epilepsy
____ Goiter
____ Heart Disease
____ Measles
____ Multiple Sclerosis
____ Mumps
____ Pleurisy
____ Pneumonia
____ Rheumatic Fever
____ Stroke
____Tonsilitis
____ Torticollis
____ Tuberculosis
____ Typhoid Fever
____ Venereal Disease
____ Whooping Cough

Check any of the following symptoms in which your child has now (N) or in the past (P):

(N) (P)
GENERAL
____ ____ Severe or frequent headaches
____ ____ SInus infections
____ ____ Frequent colds
____ ____ Allergies
____ ____ Poor appetite
____ ____ Loss of sleep
____ ____ Loss of weight
____ ____ Nervousness
____ ____ Dizziness
____ ____ Fainting
____ ____ Colic

NERVOUS SYSTEM
____ ____ ADD/ADHD
____ ____ Anxiety
____ ____ Autism
____ ____ Behavioral issues
____ ____ Cerebral Palsy
____ ____ Epilepsy
____ ____ Gait/Walking difficulties
____ ____ Learning difficulties
____ ____ Scoliosis
____ ____ SPD
____ ____ Seizures
____ ____ Tremors/Tics

GASTRO-INTESTINAL
____ ____ Belching/Gas
____ ____ Ulcer/Colitis
____ ____ Constipation
____ ____ Diarrhea
____ ____ Liver trouble
____ ____ Gall bladder trouble
____ ____ Acid reflux/difficult digestion
____ ____ Jaundice

SKIN
____ ____ Hives or allergies
____ ____ Itching or rashes
____ ____ Eczema or psoriasis

(N) (P)
E.E.N.T
____ ____ Deafness
____ ____ Earache/ear infections
____ ____ Eye pain
____ ____ Hay fever
____ ____ Sore throat
____ ____ Nasal obstruction
____ ____ Hoarseness
____ ____ Nosebleeds

CARDIOVASCULAR
____ ____ High blood pressure
____ ____ Low blood pressure
____ ____ Cold hand/feet
____ ____ Heart surgery
____ ____ Rapid/slow beating heart
____ ____ Chest pain
____ ____ Varicose veins

RESPIRATORY
____ ____ Asthma
____ ____ Chronic cough
____ ____ Difficulty breathing
____ ____ Wheezing

GENITO-URINARY
____ ____ Bed wetting
____ ____ Blood/pus in urine
____ ____ Frequent urination
____ ____ Can't control urine
____ ____ Painful urination

TERMS OF ACCEPTANCE AND CONSENT TO CHIROPRACTIC SERVICES

I, (parent/guardian) _____ hereby consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Suzanne Bowen. I will have an opportunity to discuss with Vitality Wellness Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to you to be fully informed before consenting treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Vitality Wellness Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my child's health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Vitality Wellness Chiropractic responsible for any errors or omission that I may have made in the completion of this form. I have read, or have had read to me, the full terms above of consent and have also had an opportunity to ask questions about its content. By signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my child's present condition and for any future care provided by this clinic and/or employed staff.

Parent/Guardian Signature: _____ Date: _____

PATIENT HEALTH INFORMATION / HIPAA CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with out privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care,

I have read, or have had read to me, the full terms above of acceptance and consent to chiropractic services and have also had an opportunity to ask questions about its content. By signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff. I have also read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Vitality Wellness Chiropractic is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to maintain the privacy of your PHI and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your right as a patient under the law. You have the right to review our Notice before signing this Consent, and you are advised to do so.

By signing this form you consent to our use and disclosure to third parties of you PHI for treatment, payment, health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written and dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Parent/Guardian Signature: _____ Date: _____

PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and myself. And that Vitality Wellness Chiropractic does not take insurance. I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In case of a pre-pay plan, payments made for services not utilized will be returned.

Parent/Guardian Signature: _____ Date: _____