PEDIATRIC HISTORY FORM
APPLICATION FOR CARE AT FREEDOM CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Childs Name_____ Date of Birth _____/_____/_____ Age_____

Birth Height: _____ Birth Weight: _____ Current Height: _____Current Weight: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____ Mother's Mobile _____ DOB____/____/____

Fathers name: _____ Father's Mobile_____ DOB ____/____/____

Pediatrician/Family MD _____City & State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

☐ Father's Social Security # _____-_____-_____ ☐ Mother's Social Security # _____-_____-_____

CHILD'S CURRENT PROBLEM

Purpose of this visit:

☐ Wellness Check-up ☐ Injury or Accident ☐ Other (Please explain: _____)

If your child is experiencing ***Pain/Discomfort please identify where and for how long***

_____

_____

1. **When did the** Problem first begin? Date ____/____/_____ ☐ Unknown ☐ Gradual ☐ Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: If yes, *(Describe)*:_____
4. Have you seen any **other doctors** for this problem? ☐ No ☐ Yes If yes who?_____
5. How long ago? ☐ Days ☐ Weeks ☐ Months ☐ Years

6. What were the results of past treatment?

   _____

7. How is this problem **NOW:**
   ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

8. Please list any **medication taken** for this problem:

   _____

9. Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes

   If yes, please explain:_____

10. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes

    If yes, please explain:_____

HAS YOUR CHILD EVER SUFFERED FROM:

□ Headaches	□ Orthopedic Problem	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Ache	□ Ruptures/Hernia
□ Seizures/Convulsions	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Chronic Earaches	□ Backaches	□ Diarrhea	□ Allergies: _____
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Asthma
□ Scoliosis	□ Anemia	□ Colds/Flu	□ Walking Trouble
□ Bed Wetting	□ Colic	□ Broken Bones	□ Sleeping Problems
□ Fall in baby walker	□ Fall from bed/couch	□ Fall from crib	□ Fall off swing
□ Fall off bicycle	□ Fall from high chair	□ Fall off slide	□ Fall down stairs
□ Fall from changing table	□ Fall off monkey bars	□ Fall off skateboard/skates	

□ Other: _____

OTHER MEDICAL HISTORY

1. Number of Antibiotics your child has taken in the last 6 months: _____
    a. Total of Antibiotics your child has taken: _____
2. Previous Chiropractic Care: Yes/No Previous Chiropractor: _____
    a. Time under chiropractic care: _____
3. Complications During Birth? _____
    a. Birth Interventions: ☐ Forceps ☐ Vacuum Extraction ☐ C Section
    ☐ Other: _____
4. Feeding History: ☐ Breast Fed- How Long? _____ ☐ Formula- How Long? _____
5. Food/Drink Allergies or Intolerance? _____
6. According to the National Safety Council, 50% of children fall head first from a high place within their 1st year of life. Is this true with your child? _____
7. Other Trauma: _____
8. Is your child involved in high impact sports? ☐ No ☐ Yes If yes, what events? _____
    _____
9. Vaccination History: _____

SURGERIES/HOSPITALIZATIONS/ILLNESSES

Type: _____ Date: _____

Type: _____ Date: _____

Please list your child's daily activities and the length of time they do the activity:

Daily Activities	Less than 1 hr.	More than 1 hr.	More than 2 hrs.	More than 3 hrs.
Homework:				
Athletics:				
Watching TV:				
Sleep:				
Computer Use:				
Backpack Use:				
Household Chores:				
Reading/Concentration:				
Yard work:				

ACTIVITIES OF DAILY LIVING

Please list any activities your child experiences difficulty with:

Activity	Painful (can do)	Painful (limits)	Unable to Perform

MOTOR VEHICLE ACCIDENT HISTORY

1. When was your child's' most recent auto accident? _____
   a. Speed: _____
   b. Front, side, or rear-end collision? _____
   c. Was treatment received? ☐ No ☐ Yes If yes, where? _____
2. Is there any other injury to your child's spine, minor or major that the doctor should know about?

   _____

FAMILY HISTORY

Have <u>you</u> or <u>anyone</u> in your child's IMMEDIATE family had any of the following conditions:

☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Alzheimer's ☐ Multiple Sclerosis
☐ Cancer ☐ Heart Attack ☐ Mental Illness ☐ Learning Disability
☐ High/Low Blood Pressure ☐ Arthritis ☐ Spine Problems
☐ Epilepsy ☐ Anemia ☐ Liver Trouble ☐ Digestive Problems
☐ Kidney Trouble ☐ Chest Pain ☐ Asthma

Anything not listed: _____

FINANCIAL RESPONSIBILITY

I understand that I am directly and fully responsible to Freedom Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____
Parent or Legal Guardian's Signature Date

_____ _____
Doctor Signature Date

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (Page 1)

WELCOME. We are honored to be part of your journey to better health. Please read these policies and consent carefully. We feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. If you have questions or anything is unclear, please let a member of our staff know before submitting your ***Application for Care***. It is in everyone's best interest that your decision as to whether you wish to become a patient is informed.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

FIRST THINGS FIRST: Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

CHIROPRACTIC CARE*:* When a patient seeks chiropractic care, it is essential that the patient and doctor are working toward the same objective. Chiropractic is a branch of the healing arts distinct from other branches (e.g. osteopathic or allopathic). Doctors of chiropractic view health as a continuum from optimal health, to hidden imbalances, to disease. Rather than treating disease, chiropractic aims to improve health by eliminating underlying imbalances that interfere with the body's functioning. Such imbalances include subluxation, a major interference to the expression of the body's innate wisdom. Our doctors use specific spinal correction and musculoskeletal techniques to help eliminate subluxation. We also use diagnostic testing and nutritional remedial measures to help achieve homeostasis - a dynamic equilibrium, in which the body continuously changes to maintain optimal internal stability in response to external conditions. As doctors of chiropractic, we do not prescribe drugs or perform surgery and all changes to prescription medications must be made by your prescribing provider. We may, however, recommend homeopathic and botanical medicines, vitamins, minerals, phytonutrients, antioxidants, enzymes, glandular extracts, non-prescription drugs, and medical goods and devices. Although we may screen for the prevention and early detection of cancer, doctors of chiropractic do not treat cancer. We may, however, work with patients who have cancer in conjunction with, but not replacing, drugs, surgery, or chemotherapy. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

RISKS: Chiropractic adjustment involves some risk including, without limit, fractures, disc injury, sprains, dislocation, and vascular injuries/stroke. Hidden conditions, such as tumors and vascular disorders, may increase this risk. Although the nutritional remedial measures we recommend are generally considered safe, they involve some risk including, without limit, changes in blood sugar, allergic reaction, and gastrointestinal upset. They may also may be inappropriate during pregnancy, toxic in large doses, and may interact with certain drugs. You agree to consult with your prescribing physician/provider about any prescription drugs you are taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. You also agree to immediately report suspected pregnancy or any potential interactions to us and your prescribing providers.

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (Page 2)

ALTERNATIVES: I understand that the alternatives include doing nothing and/or relying solely on care from providers in other branches of the healing arts. We always encourage you to communicate with your other health providers about your care.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for products purchased or services rendered.

PATIENT PRIVACY: The majority of care takes place in an open bay area. Accordingly, conversations you have with the doctor may be overheard by others. To maintain privacy, if you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

REPORT OF FINDINGS: To enhance understanding of our approach, you will be scheduled for a "Report of Findings" following your first appointment. Attendance is required for individuals who wish to become patients of this practice. Because the results of your examinations and care recommendations will be discussed at that time, we strongly urge you to invite your spouse or a significant other to attend. We know that when a patient's family understands the goals of care and how restoring and maintaining health can affect their lives as well, they become supportive in making important treatment decisions.

QUESTIONS AND ANSWERS: I have read and fully understand this consent, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words. Knowing the risks of chiropractic care, I consent to chiropractic care and recommendations.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!

_____ _____

Patient or Person with Authority to Consent **Date**

Note: Patient retains the above Notice of Office Policies and Freedom Chiropractic retains the signature sheet.

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (Page 3)

Patient initials: _____-retaining pages 1 & 2 of 3

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient's Name (Print) DOB

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Witness Date

FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (Page 1)

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Mark at (719) 533-0303. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (Page 2)

Patient initials: _____-retaining page 1 of 2

Freedom Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Freedom Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name (Print) DOB

_____ _____

Parent or Legal Guardian's signature Date

_____ _____

Witness Date

Freedom Chiropractic is committed to insuring the privacy and confidentiality for your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPPA).

To whom may we speak with other than yourself regarding your child's medical care? (If more than one, please list all)

☐ Spouse ☐ Child ☐ Sibling ☐ Care Giver ☐ Friend ☐ Other
Name: _____

☐ Spouse ☐ Child ☐ Sibling ☐ Care Giver ☐ Friend ☐ Other
Name: _____

☐ Spouse ☐ Child ☐ Sibling ☐ Care Giver ☐ Friend ☐ Other
Name: _____

May we leave a voicemail on your primary phone number? ☐ Yes ☐ No

May we leave a voicemail on your work phone number? ☐ Yes ☐ No

May we leave a voicemail on your alternate phone number? ☐ Yes ☐ No

May we mail medical information to your home? ☐ Yes ☐ No

I have been made aware of the privacy policies of Freedom Chiropractic, and have received (or made available to me) a copy of the Notice of Privacy Practices of Freedom Chiropractic.

_____
Patient's Name

_____ _____
Parent or Legal Guardian's signature Date