Wilson Family Chiropractic

PEDIATRIC HISTORY FORM

73 West Main Street

Sylva, NC 28779

PERSONAL HISTORY

DATE _____

FINANCIAL

Who is responsible for your bill? ❑Self ❑Medicare ❑Medicaid ❑Auto insurance ❑Other ❑Personal Health insurance

Method of Payment for Initial Visit Charges: ❑Cash ❑Check ❑Credit Card (You will be responsible for payment at time of service)

PERSONAL INFORMATION

Child's Name: _____ **Gender:** ❑Male ❑Female ❑Unspecified **Date of Birth:** ___/___/_____

Weight: _____ **Height:** _____ **Parent/Guardian Name(s):** _____

Local Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone: (____)_____ **Cell phone:** (____)_____ **Work phone:** (____)_____

How did you hear about us or, who referred you? _____

HEALTH HISTORY

Purpose of this Appointment: _____ **Previous Chiropractic Care?** ❑YES ❑NO **Last Visit?** ___/___/_____

Name of Pediatrician: _____ **Last Visit?** ___/___/_____

Are you satisfied with the care your child has received at the pediatrician? ❑YES ❑NO

Check any of the following conditions that apply:

❑Ear Infections	❑Scoliosis	❑Chronic Colds	❑Headaches
❑Allergies	❑Digestive Problems	❑ADHD	❑Recurring Fevers
❑Colic	❑Growing/Back Pains	❑Bed wetting	❑Temper Tantrums
❑Reflux	❑Seizures	❑Asthma	❑Car Accident, when? _____

Number of doses of antibiotics your child has taken in the past 6 months: _____ **Lifetime:** _____

Vaccination History: _____

Medications currently taking: _____ **Dosage:** _____ **Frequency:** _____

Medication Allergies: _____ **Reaction:** _____ **Date Began:** _____

Additional Information: _____

FEEDING HISTORY

Breast Fed: ❑YES ❑NO, How long? _____ **Formula Fed:** ❑YES ❑NO, How long? _____

Introduced to solid foods at: _____ months, **cows milk at:** _____months

Food/Juice allergies or intolerances? ❑YES ❑NO, List: _____

DEVELOPMENTAL HISTORY

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 (spinal nerve interference). At what age was your child able to:

____ Respond to Stimuli ____ Cross Crawl ____ Sit up ____ Hold Head Up

____ Respond to Visual Stimuli ____ Stand Alone ____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs)

Did your child have a fall similar to what was described above? ❑YES ❑NO, Explain: _____

Has your child been involved in any high impact or contact sports? ❑YES ❑NO, List: _____

Has your child been seen by a physician on an emergency basis? ❑YES ❑NO, if yes, List: _____

Other traumas not described above? _____

Has your daughter started her menstruation cycle? ❑YES / ❑NO, Age: _____

CHILDHOOD DISEASES

Chicken Pox: ❑YES ❑NO, Age ____ Mumps: ❑YES ❑NO, Age ____ Rubella: ❑YES ❑NO, Age ____

Whooping Cough: ❑YES ❑NO, Age ____ Rubeola: ❑YES ❑NO, Age ____ Other: _____, Age ____

PRENATAL HISTORY

Complications during pregnancy / delivery? ❑YES ❑NO **If yes, list:** _____

Ultrasounds during pregnancy? ❑YES ❑NO **How many:** ____ **Cigarette / Alcohol use during pregnancy?** ❑YES ❑NO **Amount:** ____

Medications taken during pregnancy/delivery? ❑YES ❑NO **List:** _____

Location of Birth: ❑Hospital ❑Birthing Center ❑Home ❑Other _____

Birth Intervention: ❑Forceps ❑Vacuum Extraction ❑Caesarian ❑Epidural ❑None/Natural

If Caesarian Section, was it ❑EMERGENCY ❑PLANNED. If emergency, please explain: _____

Genetic disorders/disabilities: YES / NO, List: _____ **Birth Weight:** _____ **Birth Length:** _____ **APGAR Scores** _____-_____

DEMOGRAPHICS

Race: ❑White ❑Asian ❑Japanese ❑Samoan ❑Black/African American ❑Asian Indian ❑Korean ❑Chinese ❑Vietnamese ❑ Guamanian or Chamorro Hispanic American Indian/Alaskan Native ❑Filipino ❑Native Hawaiian or other Pacific Island ❑Other _____I choose not to specify / **Multi-Racial:** ❑Yes ❑No ❑Unknown

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I chose not to specify

Preferred Language: ❑English ❑Other _____

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your and your child's results.

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Wilson Family Chiropractic (WFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- ❑ I give permission to WFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- ❑ If WFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- ❑ I give permission to WFC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media. We will only take your picture with your consent.
- ❑ I give permission to WFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- ❑ I give WFC permission to treat me in a room where there is no door. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private the doctor will provide a room for these conversations.
- ❑ By signing this form you are giving WFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Wilson Family Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of WFC. The written notice must contain the following information:

Your name, Social Security number and date of birth; / A clear statement of your intent to revoke this AUTHORIZATION;

The date of your request; and Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by WFC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, WFC will not refuse to provide treatment however, it will not be possible for WFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since WFC will be unable to contact me 3) all contact with WFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

to quality health care and health information. This authorization will remain in effect for the duration of my care at Wilson Family Chiropractic plus 7 years

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Social Security Number: ___- ___ - _____ Date of Birth: _____ ___, _____ Today's Date: _____, 20 _____

My name (please print): _____ My Signature: _____

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print):_____Signature of Personal Representative:_____

Description of Representative's Authority to Act on Patient's Behalf: _____

WILSON FAMILY CHIROPRACTIC—Terms of Acceptance

When a patient seeks chiropractic health 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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Out chiropractic method or correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnoses or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements. I, therefore, accept chiropractic care on this basis.

(print name) _____ _____

Signature Date

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby great permission for my child to receive chiropractic care.

_____ _____