Fort Valley
FAMILY CHIROPRACTIC

PEDIATRIC PATIENT

CONFIDENTIAL HEALTH RECORD

Date _____

Child's Name _____ DOB _____ /_____ /_____ Age _____ Sex _____

Address_____ Current Weight _____ Height_____

City _____ State _____ Zip _____ Mother's Name _____

Home Phone_____ Cell Phone _____ Father's Name _____

How did you hear about our office? _____ Pediatrician's Name _____

REASON FOR CONSULTING OUR OFFICE

□ Wellness check-up □ Birth trauma □ Sports □ Auto □ Fall □ Home injury □ Chronic discomfort □ Other

Please explain: _____

Primary Concern _____

Please circle pain Level ☺ 0 1 2 3 4 5 6 7 8 9 10☹

How often: Constant (75% or more) Frequently (75%-50%) Comes and goes (50%-25%) Occasionally (Less than 25%)

Can he/she describe symptoms: _____

When did the symptoms start? _____

How did the symptoms begin? _____

Since the complaint started is it getting: Better Worse Same

What aggravates the symptoms? _____

What makes the symptoms better? _____

Condition feels better in the? Morning Afternoon Evening

Have you seen anyone else for these concerns? _____

Has your child been under chiropractic care before? _____

Secondary Concern _____

Please circle pain Level ☺ 0 1 2 3 4 5 6 7 8 9 10☹

How often: Constant (75% or more) Frequently (75%-50%) Comes and goes (50%-25%) Occasionally (Less than 25%)

Can he/she describe the symptoms: _____

When did the symptoms start? _____

How did the symptoms begin? _____

Since the complaint started is it getting: Better Worse Same

What aggravates the symptoms? _____

What makes the symptoms better? _____

Condition feels better in the? Morning Afternoon Evening

Who? _____

When? _____

HEALTH HISTORY

Has your child ever suffered from?

- ○ Ear Infections
- ○ Asthma
- ○ Allergies
- ○ Colic
- ○ Scoliosis
- ○ Digestive Problems
- ○ Torticollis
- ○ Difficulty Breastfeeding
- ○ Bed Wetting
- ○ Car accident
- ○ Growing pains
- ○ Neck Pain
- ○ Back Pain
- ○ Headaches
- ○ Seizures
- ○ ADHD
- ○ Autism
- ○ Eczema
- ○ Sleeplessness
- ○ Toe Walking
- ○ Other _____
  _____
  _____
  _____

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Has your child participated in any high impact or contact sports (current or past) Please list: _____

Any serious accidents, injuries or falls? Yes/No Please list: _____

Prior Surgery? Yes / No Type and Date _____

Has your child ever been involved in a car accident? Yes / No Date _____

Other traumas not described above: Yes / No Date _____

Medications or Supplements currently taking_____

Family History _____

BIRTH HISTORY

Type of Birth: Vaginal Planned Caesarean Emergency Caesarian **Birth Intervention:** Induced Epidural Forceps Vacuum/Suction Cup

Duration of Labor _____ Complications during labor or delivery_____ Birth Weight _____

Infant feeding: Breast Formula Both Immunization History: On Schedule Delayed Selective Not Immunized

Quality of Sleep: Good Fair Poor Number of Hours Sleeping per Night _____

Did your child meet Developmental Milestones per the AAP guidelines? Yes / No

DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare you or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments to my child _____ by Dr. Nadia M. Ramirez or any other licensed Doctors of Chiropractic working at the office serving as a backup for the regular attending Doctors of Chiropractic.

I have had the opportunity to discuss with the attending Doctor of Chiropractic, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Parental Signature _____ Date _____

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PRIVACY NOTICE

We want you to know how your **Patient Health Information (PHI)** will 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. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your **PHI,** we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Fort Valley Family Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care options, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/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 the request has been presented.
5. For your security and right to privacy, the 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 Fort Valley Family Chiropractic 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 our 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, the chiropractic physician has the right to refuse to give care.
8. The patient understands and consents to the following appointment reminders or communications that will be used by Fort Valley Family Chiropractic:
    a. Cards or postcards mailed to the patient at their address provided by them; and
    b. Telephone calls to the patient's home, work and/or cell phone, leaving a message on their answering machine, voice mail, or with the individual answering the phone if the patient is not available at the time of the call; and
    c. The sign-in sheet located at the reception desk in which the patient is required to sign upon entering the office.

I certify that I and/or my dependent(s) have insurance coverage with _____ and understand that this office does not participate with any insurance companies. If you wish to submit insurance claims, ask the front desk to print an itemized receipt. The patient is responsible for submitting claims to insurance companies for reimbursement. This office is not liable for any unpaid claims by the insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance.

This consent will end when my current treatment plan is completed or one year from the date signed below.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

Patient Signature _____ Date: _____

Print Name _____

Signature of Patient Representative _____ Date: _____

Print Name _____ Relationship to patient _____