Advanced Relief Chiropractic

Pediatric History form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help serve you better, please complete the following information. We look forward to working with you! Thank you!

Date: _____ Referred By: _____

Patient Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Birth Date: _____ Sex: ____ Weight: _____ Height: _____

Names of Parents/ Guardians: _____

Name of Insurance Guarantor: _____ Guarantor Birth Date: _____

Purpose for contacting us? (Wellness checkup or Condition) _____

Other doctors seen for this condition: N/Y If yes, list doctor's name and prior treatments: _____

_____

Other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- ❑ Ear infections
- ❑ Asthma/ Allergies
- ❑ Colic
- ❑ Scoliosis
- ❑ Digestive problems
- ❑ Bed wetting
- ❑ Seizures
- ❑ ADHD
- ❑ Auto accident
- ❑ Chronic colds
- ❑ Recurring fevers
- ❑ Temper tantrums
- ❑ Headaches
- ❑ Other _____

Family History: _____

Previous chiropractor: _____ Date of last visit: _____ Reason: _____

Were you satisfied: _____

Name of pediatrician: _____ Date of last visit: _____ Reason: _____

Name of Midwife/OB-GYN: _____ Name of Doula/birth attendant _____

Number of doses of antibiotics your child has taken:

a) During the past six months: _____

b) Total during his/ her life: _____

Name and number of doses of other prescription medications your child has taken:

a) During the past six months: _____

b) Total during his/ her life: _____

History of adverse vaccine reactions? _____

Feeding History:

Breast Fed: N/Y If yes, how long? _____ Formula: N/Y If yes, how long? _____

Introduced to solids at _____ months. Cows' milk at _____months.

Prenatal History:

Complications during pregnancy? N/Y If yes, please list them: _____

Ultrasounds during pregnancy? N/Y If yes, how many: _____

Medications during pregnancy/ Delivery? N/Y If yes, please list them: _____

Cigarette/ alcohol use during pregnancy? N/Y

Location of birth: Home: _____ Hospital: _____ Other: _____

Birth intervention: Forceps: ___ Vacuum Extraction: ___ Caesarian Section: ___

Complications during delivery? N Y If yes, please list them: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Have you ever noticed your child: Fails to turn head to one side___ Head tilts to one side___ Stiff arms/legs____

Flattening/asymmetry of the head & face___ Excessive arching of the back___

Childhood diseases:

Chicken Pox: N/Y age: ___ Rubeola: N/Y age: ___ Whooping Cough: N/Y age: ___

Rubella: N/Y age: ___ Mumps: N/Y age: ___ Other: _____ N/Y age: ___

Developmental History:

At what approximate age was your child able to:

Respond to sound: _____
Respond to visual stimuli: _____
Hold head up: _____
Sit up: _____

Cross Crawl: _____
Stand Alone: _____
Walk Alone: _____

Has your child ever been involved in a car accident? N/Y If yes, please list: _____

Has your child fallen from a high place (>2 feet)? N/Y If yes, please list: _____

Prior surgery? N/Y If yes, please list: _____

Signed: _____ Relationship to patient: _____

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Informed Consent

I herby request and consent to the performance of chiropractic treatments and other chiropractic / medical procedures, including various forms of physio and physical therapy and x-rays by **Advanced Relief Chiropractic.** This consent is extended to other licensed chiropractors, chiropractic assistants and/or licensed massage therapists, who are now or in the future employed by working with or associated with this office.

I certify that I have had the opportunity to discuss with the doctor of chiropractic and/or other office personnel the nature and purpose of the care that is being provided. I understand that results are not guaranteed. Further, I have been informed and understand that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me is not expected to be able to anticipate and explain all the possible risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care based on the facts known at the time and what is in my best interest.

I give my consent to **Advanced Relief Chiropractic** staff to take and use photos for the purposes of treatment, education, professional journals, and/or advertisement.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and treatment options have been explained. By signing this consent form I agree to the care being provided to me for the entire course of treatment for my present condition(s) or for any future condition(s) for which I seek treatment.

I authorize assignment of my insurance rights and benefits directly to this provider. I authorize the release of such information as needed to process insurance claims by the provider. I designate this provider/practice as authorized representative with durable power of attorney in insurance related matters only. I understand I am responsible for all charges including collection fees or other expenses occurred by the provider in collecting on my account.

Printed Name: _____

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

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Patient Health Information 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. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information 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 this chiropractic office to use the Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
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 effect 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 that 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 chiropractor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: _____ **Date:** _____

CHIROPRACTIC APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your chiropractic care to Advanced Relief Chiropractic. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a $25 fee directly to the patient.

- This $25 fee will need to be paid in full before you will be able to schedule another appointment with Advanced Relief Chiropractic

- If you reschedule your appointment within 24 hours, we may waive the $25 fee as a courtesy.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact us and we may be able to waive this fee. You may contact us by email or by calling us and leaving a message if we are unable to answer. We do check our messages 7 days a week.

Advanced Relief Chiropractic (630)907-1300
drdanielpurdue@gmail.com

I have read and understand the Chiropractic Appointment Cancellation/No Show Policy and agree to its terms.

_____

Signature (Parent/Legal Guardian) Relationship to Patient

_____

Printed Name Date