

# BROOKE STILLWELL CHIROPRACTIC CHILDREN'S HEALTH HISTORY FORM

Today's Date \_\_\_\_\_

## ABOUT THE CHILD

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Names and Ages of Siblings \_\_\_\_\_

### Parent A

### Parent B

Name \_\_\_\_\_ Name \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Home phone (\_\_\_\_\_) \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Home phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

E-mail \_\_\_\_\_ E-mail \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Dr. Brooke can address for your child? \_\_\_\_\_

Related to:  Sports  Auto  Fall  Chronic  Home Injury  Other \_\_\_\_\_

Please describe how these concerns are affecting your child's quality of life. \_\_\_\_\_

Check all that apply  School  Exercise/Sports  Walking  
 Playing  Sleep  Attention/Focus  
 Communication  Eating  Daily Routine

## EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply  Symptomatic relief of pain or discomfort  
 Correction of the cause of the problem as well as relief of symptoms  
 Prevention of future problems  
 Healthier spine and nerve system  
 Optimal health on all levels  
 OTHER \_\_\_\_\_

# HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

## PREGNANCY & BIRTH

During pregnancy, did the mother:

- Experience any significant illnesses, difficulties, or trauma? \_\_\_\_\_
- Take any drugs/medications? \_\_\_\_\_
- Smoke or consume alcohol \_\_\_\_\_

- Home birth
- Hospital birth
- Vaginal
- Water birth
- Caesarean

Was the delivery premature?  No  Yes Weeks \_\_\_\_\_ Weight \_\_\_\_\_

Approximately how long did labor last? \_\_\_\_\_ hours

Was labor artificially induced?  No  Yes \_\_\_\_\_

Was it determined that the child was breech or otherwise malpositioned?  No  Yes \_\_\_\_\_

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

- Epidural
- Forceps
- Vacuum
- Medications \_\_\_\_\_
- Pitocin
- Episiotomy
- Manual traction of the neck \_\_\_\_\_

Please check all that apply to the baby's status immediately after birth:

- Jaundice
- Respiratory problems
- Broken bones \_\_\_\_\_
- Feeding problem
- Displaced joints
- Other conditions \_\_\_\_\_

Was the baby breastfed?  No  Yes For how long? \_\_\_\_\_

## CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Please check all that apply and give any necessary details:

- Child exposed to second hand smoke.
- Has taken antibiotics. Explain \_\_\_\_\_
- Currently taking medication. Explain \_\_\_\_\_
- Currently taking supplements. Explain \_\_\_\_\_
- Has allergies. Explain \_\_\_\_\_
- What treatments have you used? \_\_\_\_\_

## PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?:  Sports  Auto  Fall  Chronic  Home Injury  Other

Please check all that apply to your child and give any necessary details:

- Uncoordinated/Accident prone
- Has been hospitalized. \_\_\_\_\_
- Had a severe trauma. \_\_\_\_\_
- Been in an automobile accident. \_\_\_\_\_
- Has fractured a bone or dislocated a joint. \_\_\_\_\_
- Has/had a chronic illness. \_\_\_\_\_
- Has had surgery. \_\_\_\_\_

What physical activities does your child participate in? \_\_\_\_\_

## EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

- Academic pressure
- Loss of a loved one
- Bullying
- Relocation
- Lifestyle change
- Parents' divorce
- Loss of a pet
- New sibling

Does your child have difficulty interacting with schoolmates or friends?  Yes  No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?  Yes  No

## HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care?  Y  N Name of D.C. \_\_\_\_\_

Reason \_\_\_\_\_ How long? \_\_\_\_\_ Date of last visit \_\_\_\_\_

Why was care stopped? \_\_\_\_\_

Have you consulted or do you regularly consult any of the following providers for your child?

- Check all that apply
- Medical Physician
  - Naturopath
  - Acupuncturist
  - Homeopath
  - Massage Therapist
  - Psychotherapist
  - Other

Reason \_\_\_\_\_

## Visit Payment

All charges will be discussed before any services are rendered. It is our policy that all new patients joining our practice pay for their first two visits in full on this initial visit. My method of payment today will be:

Please indicate your method of payment.     Cash             Credit Card

### CONSENT TO TREATMENT OF A MINOR CHILD PLEASE READ AND SIGN

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Brooke Stillwell permission to administer health care as she deems necessary to my child.

Child's Name: (Printed) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Parent or Legal Guardian's Name: (Printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_

*Thank you for choosing Brooke Stillwell Chiropractic.*

# HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Brooke Stillwell Chiropractic**  
205 T Turnpike Road  
Southborough, MA 01772  
(508) 353-0483

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **2. Your Rights**

- **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **March 14<sup>th</sup>, 2007.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

## Notice of Privacy Practices

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

I have received a copy of the HIPAA for Brooke Stillwell Chiropractic.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

### *Appointment Reminders and Health Care Information Authorization*

The following office procedures allow Brooke Stillwell Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including email) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience at Westwood Family Chiropractic.
- We often take and post photos of our practice members/patients in the office and in our newsletters

**You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Brooke Stillwell Chiropractic.**

**This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.**

Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
BSC representative

\_\_\_\_\_  
Personal representative printed

\_\_\_\_\_  
Personal representative's relation to patient

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
BSC representative

