

Pediatric New Patient Information

Patient Information

Child's Name _____

Parent(s)/Guardian(s) _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? Yes No

E-mail _____

Child's Birth date _____ Age _____ Weight _____ Height _____

Date of your child's late Chiropractic Adjustment? _____

How did you find out about our office?

Is your child receiving care from other health professionals? Yes No If yes, please name & specialty

Please list any drugs or medications your child is taking

Please list any vitamins/herbs/homeopathics/other your child is taking

Allergies? _____

Favorite Hobbies/Activities

Current Health

Is there a health condition that brings your child to our office? _____

When did the symptoms first begin? _____

Did the problem start: Suddenly Gradually Post-Injury

Is this condition Getting Worse Improving Intermittent Constant Not Sure

What makes the problem better and/or worse?

Has your child ever had a similar condition? Yes No

Has your child been treated for this problem before? Yes No

Does your child eat well? Yes No Does your child have regular bowel/bladder movements? Yes No

Has your child ever been checked for vertebral Subluxations? Yes No Don't Know

Pediatric New Patient Information

Health History

Child's birth was Natural vaginal (no medications/interventions) Vaginal with interventions Induction
 Pain medication Epidural Episiotomy Vacuum extraction Forceps C-section Scheduled
 Emergency Other _____

Please explain interventions/complications _____

Child's birth weight _____ Child's birth height _____ APGAR score at birth _____ APGAR score (5 min) _____

At what age did your child: Respond to sound ____ Follow an object ____ Hold head up ____ Vocalize ____

Sit alone ____ Teethe ____ Crawl ____ Walk ____

Patient/Hospitalizations/Surgical history: _____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:

Is/was your child breastfed? Yes No If yes, how long? _____ If not, please explain: _____

Formula introduced at age ____ What type? _____

Introduction of cow's milk at age ____ Began solid foods at age ____ Any difficulty with bonding? Yes No

Did mother smoke during pregnancy? Yes No Did mother drink alcohol during pregnancy? Yes No

Any illness of mother during pregnancy? Yes No If yes, please explain _____

List any drugs/medications (including over the counter)/supplements taken during pregnancy

Has your child ever had: Vision Problems Headaches Breathing problems/Asthma ADD/ADHD
 Ear Aches/infections Frequent Colds Colic Digestive Problems Bed Wetting

Has your child received any vaccinations? Yes No If yes, which ones? _____

Has child received any antibiotics? Yes No If yes, how many times and why? _____

Any behavioral problems? Yes No Please explain _____

Any night terrors, sleepwalking or difficulty sleeping? Yes No

Does your child seem "normal" for their age? Yes No Please explain _____

The above information is true and accurate to the best of my knowledge. I authorize the NCWC to render necessary services to me and understand that I am responsible for all charges incurred.

Parent/Guardian Signature _____ Date _____

Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and **preservation of health**.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays) if needed.

Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the **removal and/or reduction of nerve interference** caused by subluxation.

Adjustments are made by chiropractors in order to **correct or reduce** spinal and extremity joint subluxations. The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.

By signing below, you acknowledge that you have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments will be explained, including the risks, consequences and probable effectiveness of each, upon request. You will be advised of the possible consequences if no care is received. This office makes no guarantees concerning the results of the care and treatment that we offer.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I WILLINGLY AUTHORIZE NETWORK CHIROPRACTIC WELLNESS CENTER & BJORN BOSTROM, DC TO PROCEED WITH CHIROPRACTIC EXAMINATION AND CARE.

Print Patient Name

Date

Patient Signature

Doctor Signature

Parental Consent for Minor Patient

I give permission for the above named minor patient to be managed by the doctor, in and/or out of my presence.

Signature

Relationship to Patient

PATIENT INFORMATION PRIVACY

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Network Chiropractic Wellness Center (NCWC) will not use or disclose protected health information without a valid authorization form, except as permitted or required by the HIPAA rule. When NCWC obtains or receives a valid authorization form for use or disclosure of protected health information, such use or disclosure will be restricted to that which is the minimum necessary to accomplish the purpose described in the authorization form.

Each authorization form has to be specific to the release under consideration. The specific requirements for authorizations are outlined below.

1. Return all authorizations known to be defective to the party requesting the information with an explanation of why the requested information is not being disclosed, or
2. Have the patient review the defective authorization and have the patient read and sign a new authorization form before releasing the health information.
3. A description of each purpose of the requested use or disclosure. The statement, "at the request of the individual," is a sufficient description of the purpose when an individual does not desire to make an explanation.
4. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.
5. Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.

The authorization form must contain statements adequate to place the individual on notice of all of the following:

- The individual's right to revoke the authorization in writing; and
- The potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by this regulation.

The covered entity must provide the individual with a copy of the signed authorization.

A valid authorization may also contain elements or information in addition to these required elements, provided that such additional information is not inconsistent with the required elements stated above.

If the individual refuses to sign the authorization form, the covered entity cannot condition treatment on failure to obtain such authorization

A covered entity may not use or disclose protected health information to a requesting party if the authorization is defective. A defective authorization is one that has expired, is incomplete, has been revoked, or is known to be false.

Print Patient Name

Date

Patient Signature