CONFIDENTIAL PATIENT INFORMATION – PEDIATRICS (12 and under)

Patient Name_____ Date _____ SSN_____
Home Ph._____ Cell Ph(Parent)._____
Address _____ City _____State _____ Zip _____ Sex M F
Age _____ Birth Date_____ Current Height _____ Current Weight _____
Name of Parents/Guardians _____ Occupation _____
Parent's Employer_____ Office Ph. _____
Work Address_____ Email Address_____
Who may we thank for referring you? _____
Has your child previously had chiropractic care? ☐ Yes ☐ No If yes, who was the doctor and when? _____
Would you like to receive ☐ Email Reminders ☐ Text Reminders, Cellular Carrier: _____

REASON FOR VISIT

☐ 1st Wellness Baby Check Up ☐ Preventative Child Evaluation ☐ Injury or Specific Condition
Please explain: _____

_____

_____

If your child has a specific injury or condition you would like to have evaluated, please describe below. If Wellness Baby Check Up or Preventative Child Evaluation, please go to page 3.

PRIMARY:_____

_____

When did it start? _____ Have they had it in the past: ☐ Y ☐ N When: _____
Please check the appropriate box: The symptom is ☐ constant ☐ it comes and goes
What makes it better? _____
What makes it worse? _____
Is this the result of an automobile accident: ☐ Y ☐ N If yes, please explain: _____
Have they received any other treatment for this condition: ☐ Y ☐ N If yes, indicate treatment:
☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____ Doctor's Name who provided Treatment: _____
*DOCTOR USE ONLY: _____

_____

SECONDARY:_____

_____

When did it start? _____ Have they had it in the past: ☐ Y ☐ N When: _____
Please check the appropriate box: The symptom is ☐ constant ☐ it comes and goes
What makes it better? _____
What makes it worse? _____
Is this the result of an automobile accident: ☐ Y ☐ N If yes, please explain: _____
Have they received any other treatment for this condition: ☐ Y ☐ N If yes, indicate treatment:
☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____ Doctor's Name who provided Treatment: _____
*DOCTOR USE ONLY: _____

_____

_____

Traumas: Please list traumas your child has experienced in life (auto accidents, major falls, birth trauma, etc.)

1._____Date_____
2._____Date_____
3._____Date_____

Surgery: Please list any surgeries your child has had and the date of the surgery

1._____Date_____
2._____Date_____

Medication: Please list all medications your child is currently taking. We offer information as to what nutrient deficiencies will be caused by the medications your child is taking. If you desire this information, please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Number of doses of Antiobiotics your child has taken:
During the last 6 months _____ During his/her lifetime _____

Nutrients: Please list all nutrients your child is currently taking. We offer to evaluate the formulations of the supplementation. If you desire this evaluation please bring the nutrients on your next visit.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Family History: Insert age and check any box that applies

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Bck Pain	Carpal Tunnel	Head aches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other ____												

Doctor's Use Only: _____

_____

Childhood Diseases:

☐ Chicken Pox, Age _____ ☐ Rubella, Age _____ ☐ Whooping Cough, Age _____
☐ Mumps, Age _____ ☐ Rubeola, Age _____ ☐ Other, _____Age _____

Please circle the following conditions your child has suffered from during the past six months:

ADHD
Asthma/Allergies
Autism
Bed Wetting
Car Accidents
Chronic Colds
Colic
Digestive Problems
Ear Aches
Growing Pains
Headaches
Recurring Fevers
Scoliosis
Seizures
Temper Tantrums
Other:
_____
_____

LIFESTYLE: Lifestyle, diet and exercise habits play an extremely important role in overall health and risk of chronic disease. The following questions are designed to help us understand your habits and your desires as well as commitments to make changes to those habits if necessary.

Prenatal History:

1. Y N Did you (Mother) receive chiropractic care during pregnancy? If yes, frequency_____

2. Y N Were there any complications during pregnancy? If yes, please explain_____

3. Y N Were any Ultrasounds performed during pregnancy? If yes, how many _____

4. Y N Was any medication taken during pregnancy? If yes, please list _____

5. Y N Was any medication taken during the delivery? If yes, please list _____

6. Y N Was there any use of cigarettes or alcohol by the mother during pregnancy?

7. The baby was born ☐ at home ☐ in a birthing center ☐ hospital

8. The baby was born via ☐ vaginal birth ☐ planned Caesarian section ☐ emergency Caesarian section

9. The baby presented as ☐ HEAD FIRST ☐ breech ☐ transverse lie

10. The following intervention was used during the birth ☐ forceps ☐ vacuum extraction

11. Y N Were there any complications during delivery? If yes, please explain _____

12. Y N Was the baby born with any genetic disorders or disabilities? If yes, please explain_____

13. Birth weight _____ Birth length _____ APGAR scores _____, _____

Diet:

1. Y N Was your child breastfed? If yes, how long? _____

2. Y N Was your child formula fed? If yes, how long? _____ What kind? _____

3. When was your child introduced to: 1. Solid foods? _____ months 2.Cow's milk? _____ months

4. Y N Does your child have any known food/juice allergies or intolerances? If yes, please list _____

_____

5. How many servings of fruits & vegetables does your child eat a day? 0 1 2 3 4 5 6 7 8 9 10
   1 medium fruit = 1 serving 1 cup raw vegetables = 1 serving

Vaccine History:

1. Y N My child' has received all vaccines recommended by pediatrician

2. Y N My child has not received any vaccinations

3. Y N My child has had an adverse reaction to a vaccine. If yes, please explain _____

_____

Pediatrician

Obstetrician/Midwife: _____ Phone #: _____

Address: _____ City:_____ State:_____

Primary Care Physician: _____ Physician Phone #: _____

Address: _____ City:_____ State:_____

Check here if you do NOT authorize this office to communicate with my child's primary physician about the care he/she receives. ☐

Parent Name: _____ Signature: _____ Date: _____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for my child, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 4. The practice may use and/or disclose my child's PHI (which includes information about my child's health or condition, analysis, and the treatment provided to my child) in order for the practice to make analyses about my child's condition(s), treat my child, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my child's PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as my child is a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat my child.

____ 7. I give AlignLife permission to treat my child in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of his/her protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.

____ 8. The doctor recommends that my spouse be present at my report of findings visit; therefore, I hereby give permission for my child's protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my child's status.

____ 9. This office posts a notice for Patient of the Week. If my child receives that designation I authorize AlignLife to post his/her name in the office.

____ 10. I give AlignLife the authority to utilize my name and/or my child's name, written or video story and pictures to help educate others. I give AlignLife the rights to use the testimonial in the "Our Patients Speak" testimonial book, our website, diverse web marketing campaigns, print/TV ads and other marketing campaigns to help others understand the different types of problems AlignLife has helped with.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Patient's Name (Printed) _____

Parent's Name (Signed)_____

Date:_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic 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: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement, a specific process is used which is called a chiropractic adjustment. 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.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at www.AlignLife.com.

I hereby authorize this office and it's doctor (s) to administer care as they deem necessary to my son/daughter/child (upon approval of parent or guardian). I have read and understand the information above.

Print Name: _____ Sign:_____ Date_____

FINANCIAL ARRANGEMENT

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days will ultimately become your responsibility. Although we strive to provide the most accurate predictions in regards to our recommendations there are numerous insurance and healthcare variables that cannot be controlled. I have read and understand the statements above and give the doctor permission to evaluate my child. (If under 18, parent or guardian must sign the form).

I have read and understand the information above.

Print Name:_____ Sign:_____ Date:_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I authorize the release of any information deemed appropriate concerning my child's health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe to your office by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my child's injury, up to the bill, for treatment.
4. In the event any insurance company under contractual agreement refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit. I further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

I have read and understand the information above.

Print Name:_____ Sign:_____ Date:_____