LIFETIME
HEALTH AND WELLNESS

CHILDREN'S HEALTH RECORD

PLEASE FILL OUT COMPLETELY

Patient (Child) Information **Today's Date**: ________________

Name: ____ Date of Birth: ____________ Age: ______
Weight: __________ Height: __________ Gender: □Female □Male
Address: ____ City/State/Zip________________
Phone Number: ___________________________ ☐Cell ☐Home
Parent's Names: ____
Parent's Employers: ____
Parent Email: ____
Whom may we thank for referring you? ______________________________________

Reason for this Visit

Describe the purpose for this visit: ____
____
____

Is the purpose of this visit related to (Circle): Sports / Auto / Fall / Home Injury / Chronic Discomfort / Other

If other, please explain: ____
____

When did this condition begin: ____
____

Has this condition (circle one): Gotten Worse / Stayed Constant / Comes and Goes

Does this condition interfere with (circle): Sleep / Daily Routine / Other Activities

Please explain: ____
____

Has this condition occurred before? Yes / No

Please explain: ____
____

Has your child seen other doctors for this condition? Yes / No

Name of Doctor: ____
Type of Treatment: ____
Results: ____

Had a severe fall? Yes / No

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

Has your child ever taken antibiotics? Yes / No

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

If yes, please explain: ______________________________

____

____

What changes (if any) in your child's health or behavior would you like accomplished?

____

____

Is your child currently taking any medication? Yes / No

If yes, please explain: ______________________________

____

How would you rate your child's diet? □ Well balanced □ Average □ High sugar/Processed foods

Does your child consume artificial sweeteners? Yes / No

Number of hours you child sleeps: ________ hours per night _______ hours per day/naps

Sleep Quality: □ Good □ Fair □ Poor

Vaccinations

Have you chosen to vaccinate your child? Yes / No

If yes, please circle all vaccinations you child has received:

DPT MMR Polio Chicken Pox Hepatitis Other: ______________________________

Mother's Pregnancy and Labor

During the pregnancy, did the mother take any medication? Yes / No

If yes, please explain: ______________________________

____

Smoke or consume alcohol? Yes / No

Experience any illness? Yes / No

If yes, please explain: ______________________________

____

Approximately how long did labor last? ________ hours

Was labor chemically induced? Yes / No

Was labor doctor assisted? Yes / No

Was a C-Section performed? Yes / No

Were forceps or vacuum extraction used? Yes / No

Did the delivery doctor pull or twist the baby during delivery? Yes / No

Was the delivery premature? Yes / No

If yes, how far along was the pregnancy and how much did the baby weigh?

_______________ months _______________ weight

Circle any of the following if the child experienced it immediately after birth:

Jaundice Respiratory Problems Feeding Problems Displaced/Broken Joints

Other: ____

Health History

Please circle each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

Vision Problems	Pink Eye	Headaches
Ear Problems	Sleeping Disorders	Tubes in the ears
Irritability	Attention Problems	Skin Problems
Frequent Colds	Allergies	Colic
Breathing Problems	Digestive Problems	Asthma
Hyperactivity	Constipation	Bed Wetting
Learning Difficulties	Acid Reflux	Postural Problems
Hip Dysplasia	Sleep Trouble	Frequent Fever

Other: ____

Current Health Status

Is your child accident prone? Yes / No

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

Has your child been hospitalized? Yes / No

If yes, please explain: ____

____

____

Additional Comments/Concerns: ____

____

____

Child's Name: ______________________________________

Parent/Guardian Signature: ______________________________ Date: ______________

LIFETIME
HEALTH AND WELLNESS

8155 W. 94th Avenue● Westminster, CO 80021 ● (303)423-4610 ●Fax (303)431-8658

CONSENT FOR TREATMENT OF A MINOR CHILD

I HEREBY AUTORIZE THE PRACTIONERS OF LIFETIME HEALTH & WELLNESS AND WHOMEVER HE/SHE MAY DESIGNATE AS THEIR ASSISTANTS TO ADMINISTRATE CHIROPRACTIC/ACUPUNTURE/ALLERGY CARE AS HE/SHE MAY DEEM NECESSARY TO MY CHILD.

Patient's Name: ____

Parent or Guardian: ___________________________________ (Please Print)

Signed: ____________________________ Date: ____________________

Witnessed: __________________________ Date: ____________________

PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CHARGES:

Name: ____________________________ Relationship: _________________

Date of Birth: ______________________ SSN: ______________________

Address: __________________________ ___________________ _______

Street City, State Zip

Lifetime Health & Wellness
WWW.LTHAW.COM

8155 W. 94th Avenue • Westminster, CO 80021 • Phone: 303-423-4610 • Fax: 303-431-8658

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, ______________________________, have been offered/provided a copy of the Notice of Privacy Practices from this office. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in the provision of my treatment.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. The practice of C.E.O. Westminster is not required to agree to the restrictions that I may request.

I understand that my "protected health information" means health information including my demographic information collected from me, created or received by my doctor, another health care provider, a health plan, my employer, or a health care compensation center. This protected health information relates to my past, present, or future health or physical or mental condition and identifies me, or there is a reasonable basis to believe that you can identify me.

The Notice of Privacy Practices for C.E.O. Westminster is also posted in the waiting room at 8155 W. 94th Ave., Broomfield, CO 80021. The Notice of Privacy Practices is subject to change and a revised version may be requested and mailed to me or provided for me at the time of my next appointment.

Patient Name (printed): ______________________________ Date: ______________

Patient Signature: ______________________________

☐ **Please check here to authorize our office to release records to you Primary Care Physician.**

For Official Use Only

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented our office from obtaining acknowledgment
- ☐ Other (please specify): ______________________________

Staff Signature: ______________________________ Date: ______________

Chiropractic Disclaimer

To the patient: Please read the document in its entirety prior to signing it. It is important that you understand the information explained below. If you have any questions please ask before you sign.

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, and neurological testing. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by hand-guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including electrical stimulation, traction, cold packs, hydrotherapy, infrared heat, exercise, acupuncture, dry needling, massage, A.R.T., cranial therapy, rapid release, and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.
- Physical therapy

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

I have read above the explanation and risks of Chiropractic treatment and possible therapies. By signing below, I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

______________________________ ____________________

Patient/Guardian Signature Date

______________________________ ____________________

Witness Date

OFFICE POLICIES

Please read our policies and acknowledge by initialing next to each statement and sign the bottom

________ All payments are **DUE AT TIME OF SERVICE** including co-pays, co-insurance, deductible amounts, and/or non-covered procedures. If payment is not made at time of service, a **$10 billing fee** will be applied to your balance.

________ Insurance cards presented are current and accurate. We will contact your insurance to verify benefits, however, this is not a guarantee of coverage or payment. Ultimately, it is the patient's responsibility to know insurance coverage. We know your claim is processed once we receive payment and an explanation of benefits (EOB).

________ Insurance companies have 45 days to approve or deny a claim. In some cases, this may take longer if extra information is requested.

________ For any balance remaining after insurance has paid, you will be mailed a statement. Please contact your insurance company if you feel insurance has paid incorrectly.

________ If bill is not paid within 30 days of receiving statement or billing department is not contacted, a **$15 billing fee** will be applied each billing thereafter.

________ We understand there are times where you are unable to keep an appointment. We request 24-hour notice for cancelling an appointment. A **$20 fee** may be assessed if we are not contacted in time. You may leave a voicemail if the office is closed.

________ In accordance with the State of Colorado statutes, no doctor shall engage in a personal relationship with any patient outside the parameters of normal conduct of doctor-patient interaction.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CEO Westminster Inc. to release any appropriate information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release CEO Westminster Inc. of any consequences thereof. I authorize my insurance and/or attorney to pay by check made out and directly mailed to CEO Westminster Inc. Further, I agree to pay CEO Westminster Inc. the difference, if any, between the total amount of charges and the amount paid by the insurance carried and/or attorney. A photocopy of this document will be deemed as valid and binding on all parties involved.

I have read and have full understanding of all policies and HIPPA agreement of Lifetime Health & Wellness.

Patient Name: ____

Patient Signature: ____ Date: ____________________

OR

Legal Guardian Signature: ____________________________________ Date: ____________________

Relationship to Patient: ______________________________________ Witness Initials: ___________