Cornerstone FAMILY CHIROPRACTIC

PEDIATRIC HEALTH HISTORY FORM (0-12)

Discover Health Love Life

It is a 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 more comfortable. To help us serve you better, please complete the following information. We look forward to helping you discover better heath for your family.

Name _____ Soc. Sec. # _____

Age _____ Date of Birth _____ Gender: □M □ F Weight _____ Height _____

Names of Parents/Legal Guardians _____

Email _____

Cell Phone _____ Cell Carrier _____

Home Phone_____ Work Phone _____

Home Address _____ City_____ State_____ Zip_____

Whom may we thank for referring you to Cornerstone Family Chiropractic? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Cornerstone Family Chiropractic can address for you?_____

_____

Have you had this condition before? □Yes □No If yes, When?_____ Have you seen other health care practitioners for this condition? □Yes □No If yes, Who?_____

Have you had imaging for this condition: □Yes □No If yes, When?_____Where?_____

Have you had other treatments for this? □Yes □No If yes, When?_____ What?_____

Has your child suffered from any of the following conditions in the past 6 months?

□ ADHD/ADD	□Asthma/Allergies	□Autism	□Bed Wetting	□Car Accidents
□Chronic Colds	□Colic/Reflux	□Ear Infections	□Growing Pains	□Headaches
□Recurring Fevers	□Seizures	□Sensory Disorder	□Temper Tantrums	□Other:_____

OTHER DATA

Have you ever received Chiropractic care? □Yes □No Previous Chiropractor _____

Date of last adjustment _____ Why did you stop care? _____

Do you have a family pediatrician? □Yes □No Pediatrician Name _____

Date of last medical consultation _____ Result _____

Family History _____

Number of doses of antibiotics your child has taken During the Past Six Months _____ Total Lifetime: _____

Vaccination History _____

List Current Medications _____

Any Medications Previously taken for more than 6 months _____

PRENATAL HISTORY

Name of Obstetrician / Midwife _____

Complications During Pregnancy □Yes □No List _____

Ultrasounds During Pregnancy □Yes □No Number _____

Medications During Pregnancy/Delivery □Yes □No List _____

Cigarette / Alcohol Use During Pregnancy □Yes □No

BIRTH HISTORY

Location of Birth: □Hospital □Birthing Center □Home

Birth Intervention: □Forceps □Vacuum Extraction □Caesarian Section (□Emergency or □Planned)

Complications During Delivery ? □Yes □No List: _____

Genetic Disorders or Disabilities: □Yes □No List: _____

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

FEEDING HISTORY

Breast Fed: □Yes □No How Long: _____

Formula Fed: □Yes □No How Long: _____

Introduced to Solids at: _____ Months Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: □Yes □No List: _____

DEVELOPMENTAL HISTORY

During specific times in your child's development their spine and nervous system are most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Hold Head Up _____ Respond to Visual Stimuli

_____ Sit Up Alone _____ Cross Crawl _____ Stand Up Alone

_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?

□Yes □No List: _____

Is / has your child been involved in any high impact or contact type sport (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Marital Arts, etc.)? □Yes □No List: _____

_____

Has your child ever been involved in a Car Accident? □Yes □No List: _____

Has your child been seen on an Emergency Basis? □Yes □No List: _____

Other Traumas Not Described Above? □Yes □No List: _____

Prior Surgery: □Yes □No List: _____

Menarche: □Yes □No Age: _____

CHILDHOOD DISEASES

□Yes □No Chicken Pox □Yes □No Mumps □Yes □No Measles

□Yes □No Rubella □Yes □No Rubeola □Yes □No Whooping Cough

Other: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/Guardian Signature: _____ Date: _____ / _____ / _____
Parent/Guardian Name Printed: _____

Financial Information

Payment in full is expected for all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

****The self-pay fee for a new patient is $60.00, which includes the first consult and a chiropractic exam. If it is appropriate and you consent to being adjusted, the first adjustment fee is an additional $45.00****

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the "Insurance Permission" section below.

Signature _____ Today's Date _____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

"I authorize Cornerstone Family Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."

"I authorize payment be made directly to Cornerstone Family Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature _____ Date _____

Relationship to insured ☐self ☐spouse ☐child ☐other

Also, if you are <u>not</u> the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name _____ Subscriber's date of birth _____

Subscriber's gender: ☐Male ☐Female Subscriber Address _____

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Cornerstone Family 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 occasionally have mailings (including postcards) 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 occasionally 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 Cornerstone Family 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.

We at Cornerstone Family Chiropractic are very 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 policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Cornerstone Family Chiropractic's *Notice of Privacy Practices for Protected Health Information.* 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	CFC representative

Terms and Consent to Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, _____ (print name) have read and fully understand the above. Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____	_____
(signature)	(date)