Cornerstone
FAMILY CHIROPRACTIC

PEDIATRIC HEALTH HISTORY FORM

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 health for your family.

Name _____ Age _____ Date of Birth _____

Gender: □ M □ F Weight _____ Height _____

Parents/Legal Guardians Names (if you are under 18) _____

PLEASE CHECK YOUR PREFERRED PHONE NUMBER □ Cell Phone _____

□ Home Phone_____ □ Work Phone_____

Employer _____Occupation _____

Email _____

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 healthcare 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 If yes, Who? _____

Date of last visit_____ 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 If yes, list _____

Ultrasounds During Pregnancy □ Yes □ No If yes, number _____

Medications During Pregnancy/Delivery □ Yes □ No If yes, 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 If yes, list _____

Genetic Disorders or Disabilities: □ Yes □ No If yes, list _____

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

FEEDING HISTORY

Breast Fed: □ Yes □ No If yes, how long _____ Formula Fed: □ Yes □ No If yes, how long _____

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

Food/Juice Allergies or Intolerances: □ Yes □ No If yes, 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 If yes, 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 If yes, list _____

_____

Has your child ever been involved in a car accident? □ Yes □ No If yes, list_____

Has your child been seen on an Emergency Basis? □ Yes □ No If yes, list _____

Other Traumas Not Described Above? □ Yes □ No If yes, list _____

Prior Surgery: □ Yes □ No If yes, list _____

Menarche: □ Yes □ No If yes, age _____

CHILDHOOD DISEASES

Chicken Pox	□ Yes □ No	Mumps	□ Yes □ No	Measles	□ Yes □ No
Rubella	□ Yes □ No	Rubeola	□ Yes □ No	Whooping Cough	□ Yes □ No

Other _____

WE ARE HERE TO SERVE YOU, AND WE ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

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 cash fee for a new patient is $70.00, 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 $50.00. If you're an existing patient and it has been one year since you've been in our office your re-exam fee is $35. If you're an existing patient and it has been three or more years since you've been in the office your re-exam fee is $70.****

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."

"I am responsible for any services not covered by my insurance company."

Signature: _____ Date _____

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: _____

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice has been emailed to you, is posted in the office, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Cornerstone Family Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

• I give permission to Cornerstone Family Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

•If Cornerstone Family Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

•I give permission to Cornerstone Family Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

•I give Cornerstone Family Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

•I consent to my data being used for research and/or teaching purposes.

•By signing this form you are giving Cornerstone Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Cornerstone Family Chiropractic Family Chiropractic Center plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Cornerstone Family Chiropractic. The written notice must contain the following information: your name, Social Security number, and date of birth; a clear statement of your intent to revoke this authorization; the date of your request; and your signature.

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by Cornerstone Family Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, Cornerstone Family Chiropractic will not refuse to provide treatment however, it will not be possible for Cornerstone Family Chiropractic to file third party

billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since Cornerstone Family Chiropractic will be unable to contact me 3) all contact with Cornerstone Family Chiropractic regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____

Patient's name (please print): _____

Patient's Signature: _____ Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print): _____

Signature: _____ Date: _____

Description of Representative's Authority to Act on Patient's Behalf: _____
_____

Informed Consent

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.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebrae 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 vertebral subluxation.

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

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. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. 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. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I 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 have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

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 KNOWINGLY AUTHORIZE CORNERSTONE FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____
Patient Signature Date

_____
Patient Name

Parental Consent for Minor: Patient Name: _____ Patient age:_____ DOB: _____

Printed name of person legally authorized to sign for minor: Relationship to Patient: _____

Parent/Guardian: _____ Signature: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.
Printed name of person legally authorized to sign for

Patient: _____ Relationship to Patient: _____

Signature: _____ Date: _____