PEDIATRIC PATIENT HISTORY

Name of Child: _____ Date: _____

DOB: _____ Gender: M / F Main Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Grade in School:_____ School Attended:_____

Mother's Name: _____ Main Phone #: _____

Father's Name: _____ Main Phone #: _____

Referred By: _____ Pediatrician: _____

Would you like Dr. Laura to send her findings to update your Pediatrician? Y/N
It seems that patients greatly benefit when their health care providers work together.

Please check any and all insurance coverage that may be applicable in this case**:**

- ☐ Major Medical
- ☐ Worker's Compensation
- ☐ Medicaid
- ☐ Medicare
- ☐ Auto Accident
- ☐ Medical Savings Account & Flex Plans
- ☐ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Parent/Guardian's Signature Authorizing Care:_____Date:_____

Purpose of this Appointment:

_____

_____

Patient Name: _____ Date: _____

Siblings & Ages:

_____

Are mom and dad currently under chiropractic care? Y/ N
Have the kids been adjusted before? Y/ N
How does this condition affect family members?

_____

_____

Pregnancy History (Mother): (If child is adopted, answer to the best of your ability)
Did you experience any of the following during pregnancy:

- o Severe viral infection during pregnancy 1st trimester
- o Breech position during pregnancy
- o Accident or infections
- o Smoking
- o Severe stress
- o Pre-eclampsia
- o Hypertension (High Blood pressure)
- o Toxoplasmosis
- o Uncontrolled Diabetes
- o Toxemia
- o Alcohol consumption and or drug use
- o Radiation exposure

Labor and Delivery History: Did you experience any of the following during labor/delivery:

- o Hospital Birth
- o Birthing center
- o Long and/or difficult birth
- o Placenta previa
- o Forceps or suction cup used
- o Fetal distress
- o Elective C-section
- o The child was a “blue baby”
- o Home birth
- o Labor was induced
- o Delivery was rapid
- o Breech birth
- o Cord around the neck
- o Breech birth
- o Emergency C-section
- o The child was premature (2+ weeks)

Newborn History: Did the child experience any of the following as a newborn:

- o Required resuscitation/oxygen
- o Prolonged Jaundice
- o Poor sleeper
- o Immunizations in hospital
- o If yes, specify vaccine:_____ _____
- o Distorted Skull
- o Difficulty latching/sucking
- o Formula fed
- o Breast fed
- o Bottle fed
- o Colic
- o Weight at Birth:_____
- o Length at Birth:_____

Health History: Has your child ever experienced or been diagnosed with any of the following:

- o Illness accompanied by a high fever
- o Frequent headaches
- o Seizures/convulsions
- o Chronic ear infections/earaches
- o Serious Fall(s) or repetitive falls
- o Trouble with bladder control (enuresis)
- o Serious illness
- o Shortness of Breath
- o Sprains/Strains
- o Allergies to foods
- o Environmental allergies
- o Chemical sensitivities
- o Neck or back problems
- o Sleeping problems
- o Hypoglycemia (low blood sugar)
- o Joint or muscle problems
- o Chronic Colds
- o Temper Tantrums
- o Recurring Fevers

Patient Name: _____ Date: _____

- o Growing pains
- o Weight loss
- o Weight gain
- o Fatigue
- o Irritability
- o Ears Buzzing
- o Bronchitis
- o Difficulty Breathing
- o Epilepsy
- o Skin Rashes
- o Asthma
- o Dizziness
- o Diabetes
- o Head injury
- o Fainting
- o High blood pressure
- o Heart disease
- o Heart palpitations
- o Chest pain
- o Sinus problems
- o Constipation
- o Diarrhea
- o Digestive disorders
- o Rheumatic fever
- o Flushed face
- o Cold Sweats
- o Urinary Problems
- o Dental Problems
- o Sore Throats
- o Heartburn/Reflux
- o Meningitis

Developmental History: Does or did your child have any of the following:

- o Difficulty with crawling (on all fours)
- o Difficulty learning to ride a bike
- o Difficulty learning to read
- o Difficulty using utensils
- o Difficulty tying shoes
- o Poor hand-eye coordination
- o Did not crawl on all fours
- o Appears Clumsy
- o Difficulty with writing
- o Difficulty buttoning clothing
- o Difficulty/awkward walking/running
- o Difficulty sitting still or paying attention
- o At what age did your child learn to walk unassisted: _____

Neurological/Other: Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- o Hearing loss or impairment
- o Neurological disorders
- o Obsessive Compulsive Disorder (OCD)
- o ADD/ADHD
- o Dyslexia
- o Loss of balance
- o Loss of concentration
- o Loss of memory
- o Loss of taste
- o Loss of smell
- o Light sensitivity
- o Visual changes
- o Visual impairment
- o Anxiety
- o Depression
- o Autism/Autism Spectrum Disorder
- o Tourette's Syndrome
- o Other: _____

Current/Past Medications and Treatment: List any medications that your child is taking: (List names, dose and frequency):

_____

_____

_____

List any special dietary needs that your child has:_____

_____

List any supplements that your child takes:_____

_____

Patient Name: _____ Date: _____

List any special services that your child is currently receiving at school or privately:_____

_____

List any treatment that your child is currently undergoing with any health professional:

_____

_____

List sports your child has/is participating in: _____

_____

List any previous chiropractic treatment that your child has undergone:

_____

_____

List any car accident, broken bones, surgeries, or emergency medical visits your child has had:

_____

_____

_____

Do you feel that your child's social and emotional development is age appropriate? If no, please explain:

_____

Comments: _____

_____

AUTHORIZATION FOR CARE OF A MINOR
I hereby authorize Laura Murphy, DC, DICCP to evaluate and treat my son/daughter as she deems necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are property of this clinic.

_____ _____
Signature Date

_____
Relation of person completing this form

Lifetime Chiropractic 305 W State St. Williamsburg, IA 52361

Patient Name: _____ Date: _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____ Date: _____

Patient Name: _____ Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Please review options below and sign the one(s) you want to give us permission to contact you other than phone.

I, _____, give Lifetime Chiropractic permission to email me

at _____. I understand that unless both email addresses are secure, there is a possibility that it could be seen by other people.

I, _____, give Lifetime Chiropractic permission to text me

at_____. I understand that text messages are not secure and there is a possibility that they can be seen by other people.

Patient or Parent/Guardian Signature: _____

Date: _____