RADIUS CHIROPRACTIC PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS Today's Date: _____ / ______ / _______ PMID: ___________________

Child's Name: ____ Preferred Name: ____________________________________

Birth Date: _____ /_____ /_____ Age: _______ ☐ Male ☐ Female

Parent / Guardian Name(s): ____

Address: ______________________________________ City: ______________________________ State: _____ Zip: __________

Home Phone: (_____)_______-__________ Family Email Address: ____

Mother's Name: _____________________________ DOB: ______/______/________ Mother's Mobile: (_____)_______-__________
Father's Name: ______________________________ DOB: ______/______/________ Father's Mobile: (_____)_______-__________

Emergency Contact Name: ____ Relationship: _____________________________
Emergency Contact Phone Number: (_____)_______-__________

Who is your child's primary care physician? ____

Whom may we thank for referring you, or how did you hear about Radius Chiropractic?
____

REASON FOR SEEKING CARE

What is your reason for seeking care at Radius Chiropractic?: ____
____

How long has your child been experiencing this? (if applicable) ____

Did this occur: ☐Suddenly ☐ Gradually ☐ Post Injury

Is this condition: ☐Improving ☐ Worsening ☐Constant ☐ Intermittent ☐Unsure

Are there any major injuries and/or surgeries that we should know about? ☐Yes ☐ No
If yes, please explain: ____
____
____

What is this affecting that is MOST important in your child's life? (list all that apply) ____________________________________
____

Has your child seen any other providers for this condition? ☐Yes ☐ No
If yes, please specify: ____

What would you like your child to gain from chiropractic care?
☐ Resolving Conditions ☐ Overall Wellness ☐ Both

Has your child seen a chiropractor before? ☐Yes ☐ No How long ago? ______________________________

Clinic / Doctor Name: ____

What is your reason for the change? (if applicable) ____

HEALTH HISTORY

Height: ____________ ft. ______________ in. Weight: _____________________lbs.

Has your child ever experienced any of the following:

◻ Anxiety / Depression	◻ Asthma	◻ Nausea / Vomiting	◻ Digestive Troubles
◻ Diabetes	◻ Loss of Balance	◻ Neck / Back Pain	◻ Seizures
◻ Pain in Arms / Legs	◻ Irritability	◻ Sleep Issues	◻ Ear Infections
◻ Dizziness	◻ Ringing in the Ears	◻ Sensitivity to Light	◻ Bedwetting
◻ Loss of Concentration	◻ Memory problems	◻ Headaches	◻ Numbness or Tingling
◻ Stiffness / Flexibility	◻ Sinus Trouble	◻ Cold Hands / Feet	◻ Hyperactivity

◻ Other ____

Does your child have any allergies you feel like we should know about? ____________________________________
____

Is your child currently taking any medications? ◻Yes ◻ No

Please list the medication he or she is taking and what each one is prescribed for:

Name of Medication	Dosage	Reason for Taking
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________

Does your child take any vitamins or supplements? ◻Yes ◻ No

If yes, please list: ____

Does your child or has anyone in their family had any of the following?

◻ Diabetes ◻ Cardiovascular Disease ◻ Cancer ◻ Stroke

◻ Other: ____

Are there any other health challenges that your child is experiencing that you feel the doctor should know about?
____

Has your child ever been hospitalized? ◻Yes ◻ No

If yes, please specify: ____

Has your child ever had surgery? ◻Yes ◻ No

If yes, please specify: ____

Has your child ever been in a motor vehicle accident? ◻Yes ◻ No

If yes, please specify: ____

Has your child had any significant injuries or illnesses? ◻Yes ◻ No

If yes, please specify: ____

Does your child participate in any competitive sports? ◻Yes ◻ No

If yes, which sports and at what ages?

____

PREGNANCY AND FERTILITY HISTORY

Please tell us about your pregnancy: ____

Did you experience any fertility issues? ☐Yes ☐ No
If yes, please specify: ____

Did mother smoke, drink or use any recreational drugs during pregnancy? ☐Yes ☐ No

Did mother stay active during pregnancy? ☐Yes ☐ No

Did mother have any illness during pregnancy? ☐Yes ☐ No
If yes, please explain: ____

Did mother take any medications during pregnancy? ☐Yes ☐ No
If yes, please list: ____

Did mother receive ultrasounds during pregnancy? ☐Yes ☐ No
How many? ________________________ When did they occur? ______________________

Did the mother experience any mental or physical stress throughout the pregnancy? ☐Yes ☐ No
If yes, please explain: ____

Is there anything else that you feel we should know about the child's conception or pregnancy?
____
____

LABOR AND DELIVERY HISTORY

Child birth was: ☐ Natural Vaginal Delivery ☐ Scheduled C-Section ☐ Emergency C-Section

How long did you labor before delivering? __________________ How long did you push? ______________

How many weeks was your child at birth? ____

What was the position of the baby at birth? ☐ Head Down ☐ Occiput Posterior ☐ Transverse ☐ Breech

Where was your child born? ☐ At Home ☐ Birth Center ☐ Hospital
`☐ Other: ____

Were there any of the following used during the labor and delivery?
☐ Induction ☐ Pain Medications ☐ Epidural ☐ Episiotomy
☐ Forceps ☐ Vacuum Extraction ☐ Other: ______________________

Who was your midwife / OBGYN? ____

Child's birth weight: ___________________________ Child's length at birth: ______________________

APGAR score at birth: _________________________

Do you feel that there is anything else the doctor needs to know about your labor and delivery regarding your child's health?
____
____

GROWTH AND DEVELOPMENT

Did you breastfeed the baby? ☐Yes ☐ No If yes, how long? ______________________________

Did you formula feed the baby? ☐ Exclusively ☐ Supplemental ☐ None

Did the baby have difficulty breastfeeding? ☐Yes ☐ No
If yes, please explain: ____

Did your child suffer from: ☐ Colic ☐ Reflux ☐ Constipation ☐ Excessive Gas

At what age did your child:
Hold their head up: ______________________ Sit alone: ______________________________
Crawl: _________________________________ Walk: __________________________________

At what age did you introduce:
Solid food: _____________________________ Cow's milk: ______________________________

Have you chosen to vaccinate your child?
☐ Yes - on schedule ☐ Yes - on delayed schedule ☐ No

Has your child ever received any antibiotics? ☐Yes ☐ No
If yes, please specify: ____
Check all that apply regarding your child's diet:
☐ Eats Regular Vegetables ☐ Organic Food ☐ Processed Food ☐ Sugary Drinks
☐ Drinks Water ☐ Gluten Free ☐ Dairy Free ☐ Picky Eater

Does your child have any behavioral, social, or emotional challenges? ☐Yes ☐ No
If yes, please explain: ____

How many hours per day does your child spend sitting at the TV, computer, or phone? __________________________
How would you describe your child's physical activity level?
Do you feel that there is anything else the doctor needs to know about your child's growth and development?
____
____

STRESS EVALUATION

Please rate the level of stress in your child's life for each of the following categories: (0 = none, 5 = high)

Family: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
School: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Sports: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Friends: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What do you feel is your child's primary stress (if any)? ______________________________________

Where would you rate your child's current state of health:
☐ Severe Health Challenges ☐ Symptoms Present ☐ No Symptoms ☐ 100% Thriving and Healthy

Where would you like your child's state of health to be:
◻ Severe Health Challenges ◻ Symptoms Present ◻ No Symptoms ◻ 100% Thriving and Healthy

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Radius Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ______ / ______ / ______

Parent or Legal Guardian's Signature **Date**

Witness Initials

REGARDING: X-rays / Imaging Studies

please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

FOR MEN:

I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ______ / ______ / ______

Patient or Authorized Person's Signature **Date**

FOR WOMEN:

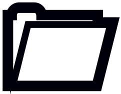
◻ The first day of my last menstrual cycle was on Date: _____ /_____ /_____

◻ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ______ / ______ / ______

Parent or Legal Guardian's Signature **Date**



Witness Initials

RADIUS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

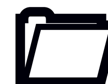
Patient initials: **_________-retaining *page 1 of 2***

I have received a copy of Radius Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ **Date of Birth:** ______ / ______ / ______

Patient's Name (Please Print)

____ ______ /______/______  *Witness Initials*

Patient's Signature **Date**

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or questions outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.

G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

____ ________ / ________ / _________

Parent or Legal Guardian's Signature **Date**

Witness Initials

Medical Information Release Form
(HIPAA Release Form)

Name: ____ **Date of Birth:** ______ / ______ / ______

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____
[ ] Child(ren) ____
[ ] Other ____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number: ____________________________

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____

The best time to reach me is (*day*) ____________________ between (*time*) ________________

____ ______ /______/______ *Witness Initials*

Patient or Legal Guardian's Signature **Date**

I understand that I am directly and fully responsible to Radius Chiropractic for all fees associated with chiropractic care that my child receives.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

___________________________________ ______ / ______ / _______

Patient or Legal Guardian's Signature **Date Completed**

___________________________________ ______ / ______ / _______

Examiner's Signature