Sundby Family Chiropractic

CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name _____

Home Phone _____ Birthdate _____

Cell Phone _____

Age _____ Gender _____

Height _____ Weight _____

Address _____

City/State/Zip _____

Parent's Name _____

Parent's Employer _____

Parent's Work Phone _____

Parent's Email Address _____

Payment Method ☐ Check ☐ Credit Card

Credit Card # _____ Exp _____

Health Insurance Co Name _____

Policy Number _____

Policy Holder's Name _____

Policy Holder's Social Security # _____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:

- take any medication? ☐ No ☐ Yes
  Explain
- smoke or consume alcohol? ☐ No ☐ Yes
- experience any illness? ☐ No ☐ Yes
  Explain

Approximately how long did labor last? _____ hours

Was labor chemically induced? ☐ No ☐ Yes

Was a C-Section performed? ☐ No ☐ Yes

Were forceps or vacuum extraction used? ☐ No ☐ Yes

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

Was the delivery premature? ☐ No ☐ Yes

If "Yes", at _____ month and _____ weight

Check any of the following if the child experienced it immediately after birth.

☐ Jaundice
☐ Feeding Problems
☐ Other Condition(s)
☐ Respiratory Problems
☐ Displaced or Broken Joints

Explain _____

REASON FOR THIS VISIT

Describe the purpose of the visit _____

_____

Is the purpose of this appointment related to

☐ sports ☐ auto ☐ fall ☐ home injury
☐ chronic discomfort ☐ other

Explain _____

When did this condition begin?

_____

Has this condition

☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with

☐ sleep ☐ daily routine ☐ other activities

Explain _____

Has this condition occurred before? ☐ Yes ☐ No

Explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Dr.'s Name(s) _____

Type of Treatment _____

Results _____

CHILD'S HEALTH HISTORY

Please check 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
☐ Headaches
☐ Sleeping Disorders
☐ Irritability
☐ Skin Problems
☐ Allergies
☐ Breathing Problems
☐ Asthma
☐ Hyperactivity
☐ Other
☐ Pink Eye
☐ Ear Problems
☐ Tubes in the Ears
☐ Attention Problems
☐ Frequent Colds
☐ Colic
☐ Digestive Problems
☐ Constipation
☐ Bed Wetting

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? ☐ No ☐ Yes

Has your child:
- been hospitalized? ☐ No ☐ Yes
- had a severe fall? ☐ No ☐ Yes
- been in a car accident? ☐ No ☐ Yes

Has your child ever taken antibiotics? ☐ No ☐ Yes
If "Yes", explain

Is your child currently taking any medication? ☐ No ☐ Yes
If "Yes", explain

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

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

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

_____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care -** Symptomatic relief of pain or discomfort

☐ **Corrective Care -** Correcting and relieving the cause of the problem as well as the symptoms

☐ **Comprehensive Care -** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ I want the Doctor to select the type of care appropriate for my child.

_____

Parent/Guardian Signature ***Date***

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors at Sundby Family Chiropractic, and whomever they may designate as their assistants to administer Chiropractic care, to work with my child (name)_____ through the use of adjustments and procedures to the spine, as the Doctor deems appropriate.
I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that the Sundby Family Chiropractic will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

_____ _____

Patient's Name (Print) ***Parent or Legal Guardian's Name (Print)***

_____ _____ _____

Parent/Guardian's Signature Authorizing Care ***Date (M/D/YY)*** ***Witness Signature***

Who should receive bills for payment on this account?
☐ Parent ☐ Personal Health Insurance ☐ Auto Insurance ☐ Medicare ☐ Medicaid

Sundby Family Chiropractic

Authorization to Release Information

_____ I authorize Sundby Family Chiropractic to release all information related to the care I receive, to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

Information about possible Risks of Treatment

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for patients with headaches and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to the vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests will be preformed to help identify if you may be susceptible to this type of injury, you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

_____I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by my Doctor of Chiropractic or other personnel involved in my care.

Assignment of Benefits

_____I assign Sundby Family Chiropractic all benefits payable to me for my care. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Signature of Patient/Guardian	Date	Relationship to Patient
Reason Patient is Unable to Sign		Witness

Sundby Family Chiropractic

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this form, stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedure concerning the privacy of your PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Sundby Chiropractic to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions to the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce these procedures in our office. We have taken all precautions, that are known by this office, to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.
8. The patient allows us to contact them by mail or by phone for scheduling purposes or educational mailings.
9. The patient allows us to print their first name and last initial in our office newsletter, testimonial, referral board, etc.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

_____ _____

Signature ***Date***