PEDIATRIC HISTORY FORM

Dear New Patient,
It is a pleasure to welcome you to our family of healthy and happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve your better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ Date: _____
Address:_____ City: _____ State/Zip: _____
Birth Date: _____ Home Phone: _____ Work Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Names of Parents/Guardians: _____

PURPOSE FOR CONTACTING US:

_____
Other Doctors Seen for this Condition: ____N ____Y , Doctors' Names and Prior Treatments:_____
_____
Other Health Problems? _____
Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma/Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing/Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other_____

_____
Family History: _____
Previous Chiropractor: _____
Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____
Date of Last Visit: _____ Reason: _____

Number of Doses of Antibiotics Your Child has Taken:
During the Past Six Months: _____ , Total During His/Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:
During the Past Six Months: _____ , Total During His/Her Lifetime: _____ List: _____
_____
Vaccination History: _____

PRENATAL HISTORY

Complications During Pregnancy: _____ N _____ Y , List: _____
Ultrasounds During Pregnancy: _____ N _____ Y, Number: _____
Medications During Pregnancy/Delivery: _____ N _____ Y , List: _____
Cigarette/Alcohol Use During Pregnancy: _____ N _____ Y
Location of Birth: _____ Hospital _____ Birthing Center _____ Home
Birth Intervention: _____ Forceps _____ Vacuum Extraction _____Caesarian Section, Emergency or Planned?
Complications During Delivery? _____ N _____ Y , List: _____
Genetic Disorders or Disabilities: _____ N _____ Y , List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

FEEDING HISTORY:

Breast Fed: _____ N _____Y , How Long: _____
Formula Fed: _____ N _____ Y , How Long: _____ Type: _____
Introduced to Solids at: _____ Months , Cows' Milk at: _____ Months
Food/Juice Allergies or Intolerances: _____ N _____ Y , List: _____
_____

DEVELOPMENTAL HISTORY:

During the following times your child's spine is most vulnerable to stress and should routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spine nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Hold Head Up _____ Cross Crawl

_____ Respond to Visual Stimuli _____ Sit Up _____ Stand Alone _____ Walk Alone

Has your child ever fallen head first from a high place during their first year of life (such as a bed, changing table, down stairs, etc.)? _____ N _____ Y , List: _____

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? _____ N _____ Y , List: _____
_____
Has Your Child Ever Been Involved in a Car Accident? _____ N _____ Y , List: _____

Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y , List: _____

Other Traumas Not Described Above: _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y , List: _____

Menarche: _____ N _____ Y , Age: _____

CHILDHOOD DISEASES

Chicken Pox	N / Y , Age: _____	Mumps	N / Y , Age: _____
Rubella	N / Y , Age: _____	Whooping Cough	N / Y , Age: _____
Rubeola	N / Y , Age: _____	Other	N / Y , Age: _____

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

AUTHORIZATION FOR CARE OF A MINOR

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

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Date: _____ Witnessed: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____

Achieve Health Chiropractic Clinic: 13911 Ridgedale Dr. Ste. 200, Minnetonka, MN 55305
(o) 952.545.3839 (f) 952.546.0168

Achieve Health Chiropractic Clinic

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 read and sign this consent 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 procedures concerning the privacy of your Patient Health Information 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 this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow their chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment and family members as needed. 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 on the use of their PHI. Our office is not obligated to agree to those restrictions. There may be a reasonable cost-based fee for photocopying, postage and preparation.
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 those 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 office manager 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 health care operations, the chiropractic physician has the right to refuse to give care.
8. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice.
9. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

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

_____

Signature of Patient **Date**

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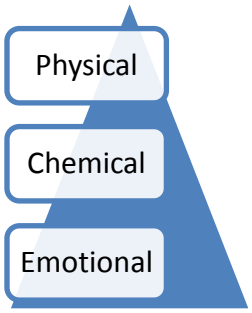

Stress Survey

Your Name: _____
Today's Date: _____
Your e-mail for our free newsletter:
_____ Please review each of these common stresses and circle when you experienced it in your life. Use **P for Past** and **C for Current**. If you expect or anticipate the possibility of experiencing this stress in the future, circle **F for Future**.

Physical Stress is what we do to our bodies:				***Explanation:***
1.Forceps delivery	P	C	F	_____
2.Falls of any type	P	C	F	_____
3.Broken bones	P	C	F	_____
4.Strains or sprains	P	C	F	_____
5.Bad posture	P	C	F	_____
6.Poor sleeping habits	P	C	F	_____
7.Repetitive movements	P	C	F	_____
8.Sports injuries	P	C	F	_____
9.Heavy lifting and/or bending	P	C	F	_____
10.Overweight	P	C	F	_____

Chemical Stress is what we do to our organs:				***Explanation:***
1.Take prescription medication	P	C	F	_____
2.Take over-the-counter drugs	P	C	F	_____
3.Consume alcohol	P	C	F	_____
4.Consume caffeine	P	C	F	_____
5.Use tobacco products	P	C	F	_____
6.Eat fast foods	P	C	F	_____
7.Use artificial sweeteners	P	C	F	_____
8.Bad diet (white flour & sugar)	P	C	F	_____
9.Exposed to environmental pollution	P	C	F	_____
10.Overweight	P	C	F	_____

Emotional Stress is what we do to our minds:				***Explanation:***
1.Divorce or parents or spouse	P	C	F	_____
2.Death of a loved one	P	C	F	_____
3.Serious illness (self or loved one)	P	C	F	_____
4.Financial concerns	P	C	F	_____
5.WORRY	P	C	F	_____
6.Work environment	P	C	F	_____
7.Relationships	P	C	F	_____
8.Anger by you or at you	P	C	F	_____
9.Feel "not worthy"	P	C	F	_____
10.Put things off to the last minute	P	C	F	_____

Chronic stress forms the foundation of many health problems. Which of the 3 types of stress has had the greatest impact on your health and why? _____

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