PEDIATRIC HISTORY FORM

Dear New Patient,

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 feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ 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: _____

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

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:

Name of Obstetrician / Midwife: _____

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

_____ Ceasarian 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 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
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Saftey 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 ? _____ N _____ Y

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 MINOR

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

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: ____ / ____ / ____

Wentzville Chiropractic and Acupuncture Center

Joan Brower D.C.; Daryl Ridgeway D.C.; Xephyr Day D.C.; Leah Owens D.C.; Jay Hauptman D.C.

CONSENT TO CHIROPRACTIC TREATMENT PLAN

THE MATERIAL RISKS INHERENT TO YOUR TREATMENT

Chiropractic care is a safe and effective approach for many health conditions, however as with any healthcare procedures, chiropractic treatments present the risks of complications or negative side effects. The list below includes the various treatments available in our clinic and the potential risks associated with these treatments.

CHIROPRACTIC EXAMINATION

Prior to establishing a treatment plan the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

CHIROPRACTIC MANIPULATION THERAPY

The risk associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. Your doctor may recommend the use of ice packs to reduce the discomfort.

HOT AND COLD THERAPY

Application of a hot or cold pack can cause a local burn. We place a towel underneath the pack to minimize this risk, however if you have very sensitive skin you may experience a reaction. Please inform your doctor if the application is uncomfortable

ULTRASOUND

The therapeutic effect of ultrasound is produced by heat. The risk associated with ultrasound therapy is burning of tissues at the application site. Ultrasound should not be painful. If you experience pain from the treatment please inform your doctor. If you have a metallic implant in the area to be treated, inform your doctor, as the implant concentrates the heat.

ELECTROTHERAPY

The therapeutic electronic current is transmitted to your body via electrodes. A small defect in the electrode coating, not always detected by observation, may concentrate the current, causing a small burn to the skin. If you feel it sting where the electrode is placed, please inform your doctor. Electronic stimulation causes muscles to contract and in rare instances a muscle cramp may occur during such treatment. Inform your doctor if the procedure is uncomfortable.

GRASTON SOFT TISSUE TECHNIQUE

A metallic instrument is used to strip a muscle or tendon, softening adhesions and promoting healing of the injured or scared tissue. In some instances this procedure may cause bruising and some reactive swelling. This may be uncomfortable, but is not causing any harm to the patient and this reaction is part of the healing process. Please inform your doctor if you are taking blood thinner medication or if you bruise easily.

LABORATORY TESTS

Laboratory tests, including the collection of a blood sample may be ordered to help diagnosis your condition. Some patients may faint at the site of needles or blood. Patients with delicate veins may experience some bruising at the skin puncture site. In very rare instances the needle can touch a nerve causing pain for a few days or a few weeks.

ACUPUNCTURE TREATMENT

Acupuncture is a generally safe treatment, but may have some side effects including bruising, numbness, tingling, itching, and dizziness or fainting. Extremely rare risks of Acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic using sterile disposable needles and maintains a clean and safe environment.

WATER TABLE THERAPY

Water table therapy uses warm, jetted water to help massage and relax your muscles. May cause redness and/or an itchy sensation to the back. Temperature can get hot, please inform your doctor if it becomes uncomfortable.

INFRARED

Laser light therapy used for intracellular healing. Infrared is great for injuries, rashes, and many other ailments. Infrared can be harmful if used incorrectly near the eyes.

HEAT LAMP THERAPY

Heat lamp therapy increases circulation, loosens fascia, and accelerates the natural healing process, mainly used in conjunction with acupuncture. May cause burning if used too close to the skin.

MASSAGE THERAPY

Massage therapy is used to relax the muscles and tendons. May cause some bruising, temporary muscle soreness, headaches and/or dizziness.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. Please check the appropriate block and sign. I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the clinic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest (or, in the case of a minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____	_____/_____/_____
(Patient's Name Printed)	**(Patient or Guardian's Signature)**	**(Date Signed)**
_____	_____	_____/_____/_____
(Witness's Name Printed)	**(Witness's Signature)**	**(Date Signed)**

Wentzville Chiropractic and Acupuncture Center

Privacy Notice Acknowledgement

1. Wentzville Chiropractic and Acupuncture Center (WCAC):

   a. Is required by federal law to maintain the privacy of your PHI (Private Health Information) and to provide you with a Privacy Notice detailing the practices legal duties and privacy practices with respect to your PHI..

   b. Is required by state law to maintain a higher level of confidentially with respect to certain portions of your medical information that is provided for under federal law.

   c. Is required to abide by the terms of this privacy notice.

   d. Reserves the right to change the terms of this privacy notice and to make new privacy notice provisions affective for all of your PHI that it maintains. .

   e. Will not retaliate against you for filing a complaint.

2. Authorization: I authorize WCAC to use and or disclose information to the following person(s):

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

☐ **I do not want any medical information released except to myself**

3. Limitations: In addition to the above, the following criteria is restricted to be released:

_____

4. Messages related to PHI: When leaving messages, I give permission to WCAC to leave a detailed message on the requested number. Please √ one or all of the following:

☐ **Home Number** ☐ **Work Number** ☐ **Cell Phone Number**

5. Voluntary Act: WCAC acknowledges that this Authorization is voluntary.

6. Revocation: I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to WCAC. However, any revocation shall not apply to the extent that WCAC has taken action in reliance on this Authorization.

7. Copy of Authorization: If WCAC has requested this Authorization from me, I understand that they will provide me with a copy of this Authorization once signed.

_____ _____

Name (Printed) Signature of Patient and or Guardian

Date: _____/_____/_____

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1023 Main Plaza Drive, Wentzville, MO 63385
(636) 639-8944 or (636) 332-8944

I hereby instruct and allow my elected insurance company to pay any billable charges to any of the listed doctors above to the following address:

1023 Main Plaza Drive
Wentzville, MO 63385

Or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you:
C/O Wentzville Chiropractic and Acupuncture Center
1023 Main Plaza Drive
Wentzville, MO 63385

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

I do understand that a quote of benefits is not a guarantee of payment. In an instance where my insurance denies payments for any circumstances the balance becomes my responsibility.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to any insurance company, adjustor, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policyholder_____

Signature of Claimant, if other than Policyholder_____

Witness_____

Date Signed: _____/_____/_____

INFORMATION FORM

DOCTOR NOTES	STAFF NOTES	ABN AT	ABN GA	MISC. NOTES

PATIENT MISSED APPOINTMENT ACKNOWLEDGMENT:

I hereby acknowledge that I will be charged a missed appointment fee if I do not call or cancel within 12 hours of my appointment time.

- **Chiropractic Appointment:** A $25.00 fee for missed appointments
- **Massage Appointment:** A fee of half of the scheduled appointment

X:_____

Date:_____

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Consent to Treat a Minor

I hereby authorize all physicians' associated with WCAC to administer chiropractic care

to my child_____ and to allow other
(Name of Minor)

treatment/therapy to be performed by others as he/she deems appropriate.

_____ _____
(Signature of Parent or Guardian) Witness's Signature

Date: _____/_____/_____