CONFIDENTIAL HEALTH REPORT-Infant-3yo

[ ] text reminders [ ] email reminders

PERSONAL INFORMATION

Child's Name (Legal) **Parent/Guardian**

Sex **Date of Birth** **Referred By**

Address **SSN**

City, State, Zip

Parents Cell Phone **Parents Home Phone** **Parent Email**

Primary Insurance **Secondary**

Insured's Date of Birth

Person Financially Responsible for Account

Name of person(s) we can discuss your care/account with (name, relationship)

Has your child had previous chiropractic care? Y / N **Chiropractor's Name(s)**

Family Doctor **Professional Designation**

Clinic Name **Date/Reason of Last Visit**

HISTORY

Does your child take any medications? **Supplements?**

Does your child have any specific illnesses?

What surgeries has your child had and when?

List ALL accidents, falls or traumas that your child has had (include falls, sports injuries and/or car accidents):

Why have you decided to have your child evaluated by a chiropractor?

□ He/she is continuing ongoing care from another chiropractor
□ I recently had my spine checked and recognize the value in getting my child checked
□ I have concerns about his/her health and I am looking to get some answers
□ He/she has a specific condition and I've heard that chiropractic care can help
□ I want to improve my child's immune function

PRENATAL

Complications during pregnancy? □ No □ Yes, Explain____
Ultrasound during pregnancy? □ No □ Yes: How many and when? ____
Medications during pregnancy? □ No □ Yes, Describe____
Exposure to alcohol, cigarettes or second hand smoke during pregnancy? □ No □ Yes

BIRTH EXPERIENCE

Location of birth: □ Home □ Hospital □ Birthing center □ Other____
Birth attendants: □ Doula □ Midwife □ OB □ GP □ Other____
Were there medications used during labor? □ No □ Yes, list____
Was your child in an intra-uterine constraint position during birth? □ No □ Yes, please circle: Breech, transverse, brow.
Was the delivery vaginal or via C-section? _____________________
Were any of the following interventions used during pregnancy? □ Forceps □ Vacuum extraction □ Other
Were there any complications during delivery? □ No □ Yes, describe____
How long were you in labor for? ______________________________
Any concerns about a misshapen head at birth? □ No □ Yes

POSTNATAL

How many weeks gestation was the baby at birth? ____W ____D / Weight at birth ____lbs ____Oz / Length _______inch
If known, APGAR score at 1min: ___/10 and at 5min: ___/10
Was the baby ever put into the NICU? □ No □ Yes, describe____
Was the baby given any medication at birth? □ No, □ Yes, describe____

HEALTH HISTORY

How many hours does your child sleep between feedings? Day_____ Night_____
Does your child have a preferred sleeping position? □ No □ Yes, describe____
Does your child have any feeding difficulties? □ No □ Yes, describe____
Is your child currently being breastfed? □ No □ Yes
Does your child have a one-sided breast preference? □ No □ Yes: Please circle, Left or Right.
Does your child frequently spit up after feeding? □ No □ Yes: Is this right after a meal or a few hours later? ____________
Does your child cry often? □ No □ Yes
Does your child pas a lot of intestinal gas? □ No □ Yes
Does your child frequently arch his/her back? □ No □ Yes
Has your child shown any sensitivity to food? □ No □ Yes, Which types? ____
Is your child exposed to dairy (cow's milk)? □ No □ Yes, formula □ Yes, directly □ Yes, I drink it and breastfeed
Has your child ever fallen from high places? □ No □ Yes
Has your child had any previous hospitalizations? □ No □ Yes, please describe_____________________________________
Has your child been seen on an emergency basis? □ No □ Yes, please describe_____________________________________
Has your child been involved in a car accident with you or family member? □ No □ Yes, please describe____
Has your child had any broken bones? □ No □ Yes, please describe____

HISTORY OF CHEMICAL STRESSORS

Has your child been exposed to vaccines? □ No □ Yes, on a delayed/selective schedule □ Yes, on schedule
Reason for vaccine: □ Informed decision □ Unsure I had a choice □ It was recommended
Were there any reactions to the vaccines? □ No □ Yes, please describe____
Has your child been exposed to antibiotics? □ No □ Yes, describe____
Has your child been exposed to medications (prescribed or OTC)? □ No □ Yes, describe___________________________
How many glasses of water does your child have each day? □ 0 □ 1-3 □ 4-6 □ 7-9 □ 10+
Does your child eat a lot of gluten, dairy refined sugar, artificial sweeteners or breads/pastas? □ No □ Yes, please describe____
Does your child take a probiotic or multivitamin on a regular basis? □ No □ Yes, please describe____

Please check any of the following symptoms in which your child currently has/had now (N) or the past (P):

N	P		N	P	
___	___	Asthma	___	___	Sinus Infections
___	___	Asymmetrical crawling or gait	___	___	Regression of milestones
___	___	Colic	___	___	Slow or absent reflexes
___	___	Trouble latching to one side	___	___	Digestive problems
___	___	Respiratory tract infection	___	___	Frequent diarrhea
___	___	Ear infection	___	___	Constipation
___	___	Strep throat	___	___	Flatulence
___	___	Tonsillitis	___	___	Headaches/migraines
___	___	Frequent colds	___	___	Neck pain
___	___	Croup	___	___	Torticollis/neck tilt
___	___	Recurrent fevers	___	___	Eczema/rashes
___	___	Back pain	___	___	Growing pains
___	___	Scoliosis			
___	___	Swollen or red joints			
___	___	Frequent crying spells			
___	___	Trouble focusing in school			
___	___	ADD/ADHD			
___	___	Weight challenges (inability to gain weight)			
___	___	Trouble sleeping			
___	___	Bed wetting			
___	___	Tip toe walking			
___	___	Seizures			
___	___	Tremors/shaking			

PRIMARY COMPLAINT: DO YOU HAVE ANY SPECIFIC CONCERNS THAT ARE BRINGING YOU IN?

□ No, I am here for wellness and would like my child's nervous system assessed to achieve optimal functioning
□ Yes, my child's primary complaint is ____

When did this start?

Where is the symptom?

Where does it travel?

Describe the symptom: Sharp Dull Aching Burning Numb Throbbing Radiating

How severe is it? 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

How often do you have it? Constant 100% • Frequent 75% • Intermittent 50% • Occasional 25% • Rare 10%

What makes it better or worse?

What movements are difficult?

What have you done for this already?

What is your primary goal for your child at our office: ____

Family Wellness Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

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 complete satisfaction. I therefore accept chiropractic care on this basis.

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 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 HIPAA 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 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 on 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 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 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 health care operations, our office has the right to refuse to give care.

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

X-RAY CONSENT This is to certify that Dr. Coppin has my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child. **If female, date of last menstrual period**:

CONSENT TO CARE FOR A MINOR I authorize Dr. Coppin and whomever she may designate as her assistant to administer care as she so deeds necessary to my son/daughter.

INSURANCE Your insurance company will only pay for services that they determine are medically necessary. As a patient you must understand that some or all services provided for your care might not be covered by your contract benefits. You as a patient are liable for all charges that your plan does not cover. I have been notified by my physician that my insurance may not cover all the services provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment. Any co-pay, coinsurance, or deductible is due at the time of service.

PERSONAL FINANCIAL RESPONSIBILITY I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Coppin will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Coppin will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I **have read and understand the above and I agree to these policies and procedures listed below:**

☐**Terms of Acceptance** ☐ **Patient Health Information Consent Form** ☐ **X-ray Consent** ☐ **Minor Consent Form** ☐ **Insurance**

Parent/Guardian Signature: ____ **Date:** ________________