PEDIATRIC HISTORY FORM

FLOURISH CHIROPRACTIC

PRACTICE MEMBER DEMOGRAPHICS

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Age: _____ Current Height: _____ Current Weight: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____City/State _____

Last Visit: ____/____/____ Reason for visit:_____

Has your child received previous chiropractic care? ☐ N

Last visit:___/ ____/ _____ Reason for visit:_____

How did you hear about our office? _____

REASON FOR PURSUING CARE:

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

Please explain: _____

Health Concerns:	Rate of Severity (1-10)	When didthis start?	Did you have this before? When?	Did this begin With an injury?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Any **bowel or bladder** problems since this problem began?:

If yes, describe:_____

Have you seen any **other doctors** for this problem? ___No ___Yes

If yes, who?_____

When? _____

What were the results of past treatment?_____

How is this problem **NOW?:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any **medication** taken for this problem: _____

Please list any present prescription drugs/doses:_____

Please list any past prescription drugs/doses:_____

Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes

If yes, please explain: _____

_____

Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes

If yes, please explain:_____

_____

BIRTH EXPERIENCE:

Birth Height: _____ Birth Weight: _____ APGAR Scores: ___ - ___

Birth Intervention**:**

☐ Forceps ☐ Vacuum Extraction ☐ C-Section (Planned) ☐ C-Section (Emergency)

Feeding:

Breast Fed: ☐ No ☐ Yes How long?_____ Formula Fed: ☐ No ☐ Yes How long?_____

At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Sit up _____ Stand alone

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches	☐ Ortho Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall on playground
☐ Fall off bicycle	☐ Fall from bed/couch	☐ Fall from crib	☐ Fall down stairs
☐ Breast-feeding trouble	☐ Other: _____		

Allergies: _____

Is there anything else you would like us to know about your child? _____

_____

What are your health goals for your child? _____

Written Consent for a Child

Name of practice member who is a minor/child: _____

I authorize Dr. Laura Piehl and any members certified of Flourish Chiropractic staff to perform diagnostic procedures, radiographic evaluation, render chiropractic care and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Flourish Chiropractic.

_____ _____

Date Guardian Signature

_____ _____

Witness Signature (Office Staff) Guardian's relationship to minor/child

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays. At your request, we will provide you a copy of your x-rays.

The fee for copying your x-rays on a disc is $10.00. This fee must be paid in advance.
Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: x-rays are used in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Flourish Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attentions so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____ _____

Guardian Signature Print Your Name Here

_____ _____

Your Age Signature

Female patients only: please read carefully and check the box, then sign below if you understand and have no further questions, otherwise see our team for further explanation.

□ 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 diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

Date Signature

Insurance Information (If Applicable)

Childs Name: _____ Date: _____/_____/_____

Name of primary insurance carrier: _____

Name of subscriber: _____ Subscriber's DOB :_____

Occupation: _____ Employer: _____

Subscriber's address: _____

Subscriber's phone number: _____

Policy number: _____ Group number: _____

Do you have a HSA/FSA? (Health/Flexible Savings Account) □ Yes ■ No

Name of secondary insurance carrier: _____

Name of subscriber: _____ Subscriber's date of birth:_____

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Flourish Chiropractic: Laura Piehl, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____

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.

_____ _____

Signature Date

Notice of Privacy Practices Acknowledgment

I understand that I have certain rights of privacy regarding protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

Signature Date

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondarily to chiropractic care include: sprain/strain of injuries, irritation of disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

_____ _____

Parent/Guardian's Name Parent/Guardian Signature

_____ _____ _____

Relationship to minor/child Date Witness Initials

Photo Release

I grant Flourish Chiropractic and its employees the right to take photos of me with connection to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Flourish Chiropractic may use such photos of me and for any lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

_____ _____

Signature Date