Date: ____/_____/_____

PEDIATRIC HEALTH HISTORY FORM

Name ____ DOB: ___/___/___ Age _____ Male/ Female

Address _____________________________________ City___________________ State _____ Zip ________

Mother's Name: ____________________________ Father's Name: ______________________________

Phone: ______________________ Cell Provider: _____________ Email: ___________________________

Names and ages of siblings: ____

Who may we thank for referring you? ____

REASONS FOR PURSUING CARE:

My child is here for ❑ Wellness ❑ Improved health ❑ Health concerns: _______________________

Health concerns related to: ❑ Sports ❑Auto ❑ Fall ❑ Chronic ❑ Injury ❑ Other_____________________

Have you seen any other doctors for these concerns? ❑ Yes ❑ No Who? _________________________

How are these concerns affecting your child's quality of life? Check all that apply:

❑ School ❑Exercise/Sports ❑Walking Other: _______________________

❑Sleep ❑ Attention/focus ❑ Communication _______________________

❑Playing ❑Eating ❑ Daily Routine _______________________

Circle any of the following conditions that currently or previously apply:

Ear infections	Scoliosis	Chronic Colds	Headaches	Other __________
Allergies	Digestive Problems	ADHD	Recurring Fevers	__________
Colic	Growing/Back pains	Autism	Temper tantrums	__________
Seizures	Asthma	Bedwetting	Language delay	__________

If there is a present health concern, how has it been progressing?

❑Rapidly Improving ❑ Improving Slowly ❑About the Same
❑ Gradually Worsening ❑ On and Off ❑ Other ________________________________

HEALTH HISTORY:

Previous chiropractic care? ❑ Yes ❑ No If so, who and when? _________________________________

Name of pediatrician? ____

# of Doses of antibiotics your child has taken in the: Past 6 months: _____________ Lifetime: __________

Present prescription drugs/dosage? ____

Previous prescription drugs/dosage? ____

Over the counter drugs? ____

Have you chosen to vaccinate your child? ❑ Yes ❑ No. If yes, check all vaccinations received:

❑ DPT ❑ MMR ❑ Polio ❑Chicken Pox ❑ Hepatitis ❑ Other ___________________________

Describe any and all reactions to vaccine(s): ____

PRENATAL HISTORY:

Name of Obstetrician/ Midwife: ____________________

Complications during pregnancy/delivery? ❑ Yes ❑ No If so, explain ____________________

Ultrasounds during pregnancy? ❑ Yes ❑ No If so, how many? ____________________

Cigarette/Alcohol use during pregnancy? ❑Yes ❑ No

Medications taken during pregnancy/delivery: ❑ Yes ❑ No If so, what? ____________________

Location of Birth: ❑Hospital ❑Birthing Center ❑Home

Birth Intervention: ❑ Forceps ❑C – Section ❑ Vacuum Extraction ❑ Pitocin

❑ Epidural ❑ Episiotomy ❑ Manual traction of neck ❑ None

If C- Section, was it: ❑ Planned ❑ Emergency

Duration of labor? ____________________

Was the birth premature? ❑ Yes ❑ No If so, at how many weeks? ____________________

Please check all that apply to baby's status immediately after birth:

❑ Torticollis ❑ Respiratory problems ❑ Broken bones ❑ Other ____________________

❑ Jaundice ❑ Displaced joints ❑ Feeding Problem ____________________

Birth Weight: __________ Length: __________ APGAR Scores: __________-__________

Was your child breastfed? ❑ Yes ❑ No How long? ____________________

GOALS/EXPECTATIONS:

I would like to experience the following benefits from Chiropractic Care:

Check all that apply:

❑ Symptomatic relief of pain or discomfort

❑ Correction of the cause of the problem as well as relief of symptoms

❑ Prevention of future problems

❑ Healthier spine and nerve system

❑ Optimal health on all levels

❑ OTHER____________________

I hereby authorize payment to be made directly to Absolute Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Absolute Chiropractic for any and all services I receive at this office.

Practice Member Signature: ____________________ **Today's Date:** ___/___/_______

Doctor Signature: ____________________ **Today's Date:** ___/___/_______

QUADRUPLE VISUAL ANALOGUE SCALE

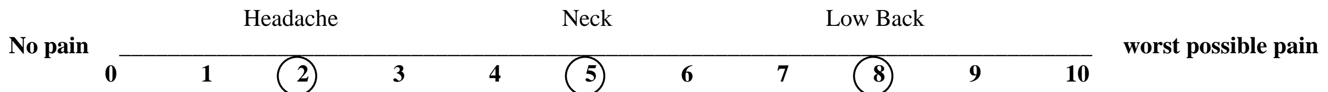
Patient Name ____ Date ___________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



worst possible pain

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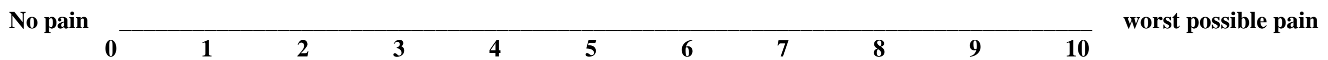
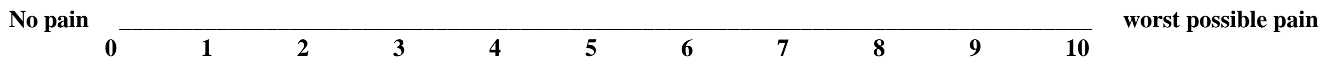
1 – What is your pain RIGHT NOW?



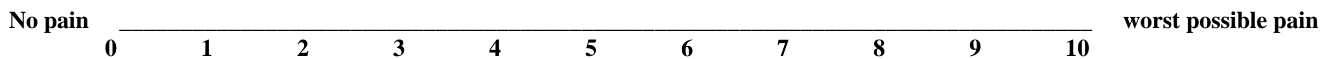
worst possible pain

2 – What is your TYPICAL or AVERAGE pain?



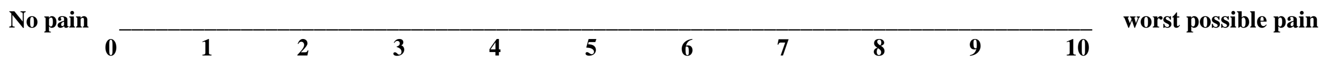
worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



worst possible pain

OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

FAMILY HEALTH HISTORY

Please mark **any** of the below conditions that you or your family have or have had in the past:
Write "C" if current issue or "P" if past issue

	Yourself	Spouse	Children	Mother	Father
Acid Reflux					
Addiction					
ADHD					
Allergies					
Anxiety/Nervousness					
Arthritis					
Asthma					
Autism Spect. Disorder					
Autoimmune Disorder					
Bladder Problems					
Chronic Fatigue					
Depression					
Disc Problems					
Dizziness					
Ear Infections					
Epilepsy					
Fainting/syncope					
Fibromyalgia					
Headaches					
Heart Disorders					
Infertility					
Irritable Bowel Synd.					
Kidney Condition					
Lupus					
Menstrual Problems					
Migraines					
Multiple Sclerosis					
Nausea					
Numbness/tingling					
Reflux					
Sciatica					
Sinus problems					
Stiffness					
Stomach Conditions					
Throat Issues					
Thyroid Problems					
TMJ Disorder					
Ulcers					
Vertigo					

PATIENT'S NAME: ____ **DATE:** ______________

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered. Some adjustments are delivered by hand, while some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and the treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

(Print Name): ____

TO BEGIN CHIROPRACTIC CARE AND TREATMENT.

Practice Member Signature: ______________________________ **Today's Date:** ___/___/___

Doctor Signature: ______________________________ **Today's Date:** ___/___/___

PARENTAL CONSENT FOR MINOR PATIENT:

Patient Name: ____________________________

Patient age: ___________ DOB: ____________

Printed name of person legally authorized to sign for Patient: ____________________________

Signature: ____________________________

Relationship to Patient: ____________________

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: ____________________________

Signature: ____________________________

Relationship to Patient: ____________________

X-RAY AUTHORIZATION

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

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze **VERTEBRAL SUBLUXATIONS.** However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS:

PRINT YOUR NAME HERE ____________________ DATE ____________________

SIGNATURE ____________________ YOUR AGE ____________________

FEMALE PATIENTS ONLY: *TO THE BEST OF MY KNOWLEDGE,* ***I BELIEVE I AM NOT PREGNANT*** *AT THE TIME X-RAYS ARE TAKEN AT ABSOLUTE CHIROPRACTIC.*

SIGNATURE ____________________ DATE ____________________

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize Absolute Chiropractic to use and/or disclose certain protected health information (PHI) about me for treatment, payment or healthcare operations (TPO) as listed in our extended Notice of Privacy Practices.

This authorization permits Absolute Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.) for TPO as listed in our extended Notice of Privacy Practices.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Absolute Chiropractic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

ABSOLUTE CHIROPRACTIC
2100 HIGHWAY 35
SEA GIRT, NJ 08750

Signed by: ______________________________ ______________________
Signature of Patient or Legal Guardian   Relationship to Patient

______________________________ ______________________
Print Patient's Name   Date

____
Print Name of Patient's Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.