

Flynn's Children and Family Chiropractic Center

Confidential Pediatric History Form

It is our 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 serve you better, please complete the following information. We look forward to working with you! Thank You!

Date: _____ Referred By: _____

Child's Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Weight: _____ Height: _____ S.S.#: _____ Birth Date: _____

Name of Parents/Guardians: _____ Phone Number: _____

Purpose for Contacting Us? _____

Other Doctors seen for this condition: Y N If yes, please list doctor's name and prior treatments: _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | |
|--|--|--|--|
| <input type="radio"/> Ear infections | <input type="radio"/> Digestive problems | <input type="radio"/> Auto Accident | <input type="radio"/> Headaches |
| <input type="radio"/> Asthma/Allergies | <input type="radio"/> Bed Wetting | <input type="radio"/> Chronic Colds | <input type="radio"/> Growing/Back pains |
| <input type="radio"/> Colic | <input type="radio"/> Seizures | <input type="radio"/> Recurring Fevers | <input type="radio"/> Other: _____ |
| <input type="radio"/> Scoliosis | <input type="radio"/> ADHD | <input type="radio"/> Temper Tantrums | _____ |

Family History: _____

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

Were you satisfied? Y N Why? _____

Previous / Current Pediatrician: _____ Date of Last Visit: _____ Reason: _____

Were you satisfied? Y N Why? _____

Number of doses of antibiotics your child has taken:

a) During the past six months: _____

b) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:

c) During the past six months: _____

d) Total during his/her life: _____

Vaccination History: _____

Feeding History

Breast Fed: Y N If yes, how long? _____ Formula: Y N If yes, how long: _____

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances: Y N

If Yes, please list: _____ Other allergies or tolerances: Y N If Yes, please list: _____

Number of Hours Sleeping per Night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Prenatal History:

Name of obstetrician/midwife: _____ Pediatrician / Family MD: _____
Location of Birth: Birthing Center: _____ Hospital: _____ Home: _____ Other: _____
Third Trimester Presentation: Vertex: _____ Breech: _____ Transverse: _____ Face/Brow: _____
Birth intervention: Forceps _____ Vacuum Extraction: _____ Caesarian Section: _____ Emergency or Planned?: _____
Complications during delivery? Y N If yes, please list them: _____
Ultrasounds during pregnancy? Y N If yes, how many: _____
Medications during Pregnancy/Delivery? Y N If Yes, please list them: _____
Cigarette/alcohol use during pregnancy? Y N
Complications during delivery? Y N If yes, please list them: _____
Generic disorders or disabilities? Y N If yes, please list them: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Childhood Diseases:

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

According to the National Safety 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? Y N – If yes, please explain: _____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y N If Yes, Please list: _____

Has your child ever been involved in a car accident? Y N If yes, please explain: _____

Other traumas not described above? Y N If yes, please explain: _____

Prior Surgery? Y N If yes, please explain: _____

Menarche: Y N If yes, at what age? _____

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

I hereby authorize Flynn’s Children and Family Chiropractic Center, LLC 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.

Signed: _____ Relationship to Patient: _____ Date: _____

TERMS OF ACCEPTANCE

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the 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 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ **Date:** _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree sign below.

Signature: _____ **Date:** _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. I have been advised that X-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

Signature: _____ **Date:** _____

Authorization to Contact You

It may be necessary for Flynn's Children and Family Chiropractic to contact you at home or at work in the event the doctor is out of the office, we need to reschedule, or to remind you of an appointment. By signing below, you give us authorization to contact you for any of the aforementioned circumstances.

Signature of Patient

Date

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 and 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 PHI, 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 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 with 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 effect 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, the chiropractic physician 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.

Signature of Patient

Date

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Flynn's Children and Family Chiropractic Center include but many not be limited to: The staff of Flynn's Children and Family Chiropractic Center. This includes:

1. Dr. Patrick Flynn
2. Ann Sargent
3. Andrea Fisher
4. Mary Socha
5. Christy Flynn
6. Lanita Mohn
7. Jeannine VandenHeuvel
8. Tonya Christoph

Please provide the necessary health care providers or vendors who may need to be consulted if related to the patient's condition. They include:

1. _____
2. _____
3. _____
4. _____

Signature of Patient

Date

