Date: _____

Adolescent Health History

(ages 7-17)

First Name: _____ Middle Initial: _____

Last Name: _____

Date of Birth: _____ Phone Number: (_____)_____

Address: _____

City: _____ State: ____ Zip: _____

Email: _____

Name of guardian(s):_____

Reason for today's visit: _____

_____

Please describe your symptoms: _____

_____

Any serious illness or hospitalizations? _____

_____

Have you had any (Please circle):

Chronic/recurring illness?	Yes No
Hospitalizations/Surgeries?	Yes No
Urinary/kidney problems?	Yes No
Problems with your heart?	Yes No
Chest pain with exercise?	Yes No
Wheezing/Coughing?	Yes No
Dizziness/fainting?	Yes No
Headaches?	Yes No
Anemia, bleeding or blood clot issues?	Yes No
Allergies/Asthma?	Yes No
Mental illness/Depression	Yes No
Visual/hearing problems?	Yes No
History of concussion?	Yes No
Loss of Consciousness/convulsions?	Yes No
History of broken bones?	Yes No
Any medical reason you should not play in sports?	Yes No

Family Medical History

- ○ Allergies/Asthma
- ○ Birth Defect
- ○ Bleeding disorders
- ○ Breast Problems
- ○ Cancer
- ○ Diabetes
- ○ Drug/alcohol abuse
- ○ Gall bladder Problems
- ○ Headaches
- ○ Heart disease
- ○ Hepatitis
- ○ High blood pressure
- ○ Kidney disease
- ○ Lung disease
- ○ Mental illness/depression
- ○ Obesity
- ○ Seizures
- ○ Stroke
- ○ Thyroid disease
- ○ Other:

Current Medications: _____

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Date: _____

Current Supplements/Vitamins: _____

_____

General ○ Fatigue ○ Weight changes ○ Excessive thirst ○ Frequent fevers ○ Sleep problems **Eyes** ○ Change in vision ○ Eye pain **Mouth/Throat/Ears** ○ Sore mouth/ tongue ○ Persistent hoarseness ○ Toothaches ○ Colds/sinus trouble ○ Bleeding gums ○ Pain/ringing of ears	**Heart** ○ Irregular/ fast beats ○ Chest pain with exercise ○ Swollen feet/ankles **Lungs** ○ Persistent cough ○ Wheezing ○ Shortness of breath ○ Difficulty breathing **Neck** ○ Stiffness ○ Swelling	**Stomach/Intestinal** ○ Poor Appetite ○ Difficulty swallowing ○ Indigestion/ heartburn ○ Black stool ○ Blood in bowel movement ○ Change in bowel habits ○ Abdominal pain ○ Constipation/ diarrhea **Bones/Joints/Muscles** ○ Painful/swollen Joints ○ Back pain ○ Pain in legs/feet ○ Muscle weakness ○ Limp	**Urinary** ○ Pain/burning ○ Bed wetting ○ Bloody/dark urine ○ Discharge ○ Itching **Skin** ○ Rash/hives ○ Slow healing ○ Acne ○ Dry/itchy skin **Nervous System** ○ Numbness/ tingling ○ Loss of balance ○ Speech problems ○ Headaches ○ Blurred vision

Comments:_____
_____
_____

Authorization for Care of Minor

I HEREBY AUTHORIZE BROWN FAMILY CHIROPRACTIC, LLC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY
SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

Patient Name: **_____** ***Date:*** **_____**

Signature of guardian: **_____** ***Date:*** **_____**

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form, discuss it with your clinician if you'd like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as, joint adjustment, manipulation or mobilization, or required to inform patients that there are or may be some risks associated with such treatment. In particular:

A. While rare, some patients have experienced muscles and ligaments sprains or strains, or rib fractures following spinal manual therapy.
B. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.
C. There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than your risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes. it is the responsibility of the patient to make it known whatever she/he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic.

Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and any treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis, and extremities (shoulder, upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Print name: _____ Signature:_____

Guardian Name: _____Guardian Signature:_____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in the office and your rights concerning those records. Before we will begin any healthcare 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 HIPPA 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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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. Our office may contact you periodically regarding appointments, treatments, products, services or charitable work performed by our office. you may choose to opt-out of any marketing or fundraising communications at any time.
6. 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.
7. patients have the right to file a formal complaint with our privacy official and the Security of HHS about any posible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. you will be provided with the new notice at your next visit following the change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment healthcare operations, the chiropractic physician has the right to refuse to give care.
11. I authorize Brown Family Chiropractic, LLC to bill my insurance company and asking payment of benefits directly to the office of Brown Family Chiropractic, LLC.

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

Name of Patient: _____Date: _____

Signature of Patient:_____