Date: ______________

Pediatric Health History

(Ages 0-6)

Patient Name: ____
Address: ____
City: __________________________________ **State:** ______________ **Zip:** ____________
Date of Birth: _____________________ **Phone Number:** (_______)________-____________

Reason for seeking care: ____
Please describe child's symptoms: ____
____
Current Medications, including dosage if known.
1.) _______________________________ 3.)____________________________________
2.) _______________________________ 4.)____________________________________
List any known allergies you have had to any medications. If no allergies are known, check here:
1.) ________________________________ 2.) ___________________________________
Has any doctor diagnosed your child with Hypertension presently? YES NO
If yes, describe: ____
Has any doctor diagnosed your child with Diabetes presently? YES NO

- If yes, what kind? Type 1 or Type 2
- ***If yes to Diabetes, was your blood lab work test for hemoglobin A1c>9.0%?*** **YES NO**

Has your child recently had an X-ray/MRI/CT? YES NO
If yes, please specify region and reason for imaging: ______________________________
Family History (*please circle all that apply)*

- Diabetes
- Heart Disease
- Cancer
- Hypertension
- Kidney Problems
- Stroke
- Other:

Please fill out this section if your child is newborn to 6 months old:
CIRCLE:
Yes No Does your baby have a preferred sleeping position?
Yes No Does your baby cry if you change this sleeping position?
Yes No Does your baby have any feeding difficulties?
Yes No Does your baby have one sided breastfeeding preferences?
Preferred breast: LEFT RIGHT
Yes No Does your baby frequently spit up after feeding?
Yes No Does your baby cry a lot? For how many hours each day? ____________________
Yes No Does your baby pass a lot of intestinal gas?
Yes No Does your baby frequently arch his/her head and neck backwards?
Yes No Does your baby cry or become irritable during a diaper change?

Please fill out this section if your child is 6 months to 6 years old:

Date: _______________

Yes No Is your child eating solid food? Child's favorite food?__________________________
What foods does your child's typical diet contain?______________________________________
____
Yes No Does your child have any feeding difficulties?

- Please describe:____

Yes No Does your child ever bang his/her head repeatedly against a wall, bed or other object?
Yes No Does your child frequently get ear infections?
Yes No Does your child complain of pain or discomfort?

- If so, where?____
- Was the onset Sudden or Gradual? ____
- Is the pain Constant or Intermittent? ____

Yes No Does your child ever complain of back or neck pain?
Yes No Does your child ever complain of pains in the legs or arms?
Yes No Does your child have earaches? At what age did the child's first earache occur?____

- How frequently are the ear aches?____
- In which ear? Left Right Both

Yes No Has your child ever been on antibiotics?

- If yes, at what age(s):____

Yes No Any serious illness or trauma?____
Yes No Any hospitalizations? ____

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)

Childs Name: ____ DOB: ________________________

Parent signature: ______________________________________ Date: ________________________

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:____