Alive CHIROPRACTIC

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS **Today's Date: _____ /_____ / _____** **PMID#:_____**

Child's Name: _____ Birth Date: _____ /_____ / _____ Age: _____ ☐ Male ☐ Female

Birth Height:_____ Birth Weight:_____ Current Height:_____ Current Weight:_____

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

Family E-mail: _____ Home Phone: _____

Mother's Name:_____ DOB_____ /_____ / _____ Mother's Mobile: _____

Father's Name:_____ DOB_____ /_____ / _____ Father's Mobile: _____

Pediatrician/Family MD _____ City/State_____

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

Who is responsible for this bill?_____

☐ Other (please explain): _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other (please explain): _____

If your child is experiencing ***Pain/Discomfort, please identify where and for how long*** this has been going on

1. **When did** the problem first begin? Date: _____ /_____ / _____ ☐ Unknown ☐ Gradual ☐ Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began? ☐ No ☐ Yes If yes, describe: _____
4. Have you seen any **other doctors** for this problem? ☐ No ☐ Yes If yes, who?: _____
5. **How long ago** did you see someone for this problem? ☐ Days ☐ Weeks ☐ Months ☐ Years
6. What were the **results** of the past treatment? _____
7. How is this problem **NOW**? ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off
8. Please list any **medication taken** for this problem:_____
9. Has your child ever sustained any **injuries** playing organized sports? ☐ No ☐ Yes If yes, please explain:

   _____
10. Has your child ever sustained an injury in an auto accident? Yes If yes, please explain:

    _____

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

___ Headache
___ Dizziness
___ Fainting
___ Seizures
___ Convulsions
___ Heart Trouble
___ Chronic Earaches
___ Sinus Trouble
___ Scoliosis
___ Bed Wetting
___ Fall in baby walker
___ Fall from changing table
___ Orthopedic Problems
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Joint Problems
___ Backaches
___ Poor Posture
___ Anemia
___ Colic
___ Fall from bed or couch
___ Broken Bones
___ Fall off slide
___ Fall from crib
___ Poor Appetite
___ Stomach Aches
___ Reflux
___ Constipation
___ Hypertension
___Fall off skateboard
___ Fall from high chair
___ Digestive Problems
___ Fall off monkey bars
___ Colds/Flu
___ Behavioral Problems
___ ADD/ADHD
___ Ruptures/Hernia
___ Muscle Pains
___ Growing Pains
___ Asthma
___ Walking Trouble
___ Sleeping Problems
___ Fall off swing
___ Fall down stairs

☐ Allergies to_____

☐ Other: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Alive Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____

Patient or Authorized Person's Signature Date

REGARDING: Written Consent for a Minor/Child

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD: _____

I Authorize Dr. Robert Fugiel and any and all Alive Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child.
As of this date, I have 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 Alive Chiropractic.

_____ _____ / _____ / _____

Guardian's Signature Date

_____

Guardian's Relationship to Minor/Child

REGARDING: X-Rays/Imaging Studies

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-RAY FILMS.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $5.00. 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 UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR AT ALIVE CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; 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**

_____

Patient or Authorized Person's Signature

REGARDING: X-Rays/Imaging Studies -- FEMALE PATIENTS ONLY

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____/____/____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am NOT PREGNANT at the time x-rays are taken at Alive Chiropractic.

_____ ____/____/____

Patient or Authorized Person's 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 question 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 type(s) 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.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I hereby authorize payment to be made directly to Alive 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 Alive Chiropractic for any and all services I receive at this office.

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.

_____ _____ /_____ /_____
Patient or Authorized Person's Signature Date Completed

_____ _____ / _____ / ____
Alive Chiropractic Representative Signature Date Form Reviewed

ALIVE CHIROPRACTIC OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception area. Once you have read this notice, please sign the last page, and return to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers in your care.
2. Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation – to process a claim or aid in investigation.
5. Emergency – in the event of emergency we may notify a family member.
6. For public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restriction on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restriction, we are not required to agree with them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). 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 $5.00. This fee must be paid in advance.** (*Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice).*

I have received a copy of Alive Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____/_____/_____

Patient or Authorized Person's Signature Date

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE)

Name: _____ Date of Birth: _____/____/_____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

CLINICAL EXAM FINDINGS – *This page for office use only*

Subluxation/Palp:

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
LSI
RSI
SAC

Cervical	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	☐
Extension	☐	☐	☐	☐	☐	☐
L Lat Flex	☐	☐	☐	☐	☐	☐
R Lat Flex	☐	☐	☐	☐	☐	☐
L Rotation	☐	☐	☐	☐	☐	☐
R Rotation	☐	☐	☐	☐	☐	☐

Thoracic	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	☐
L Rotation	☐	☐	☐	☐	☐	☐
R Rotation	☐	☐	☐	☐	☐	☐

Lumbar	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	☐
Extension	☐	☐	☐	☐	☐	☐
L Lat Flex	☐	☐	☐	☐	☐	☐
R Lat Flex	☐	☐	☐	☐	☐	☐

Posture:

FHP + -
Head Tilt R L
Head Rotation R L
High Shoulder R L
Thoracic Tilt R L
Thoracic Rotation R L
High Hip R L
Foot Flare R L
Short Leg R L

Notes:

Infants & Newborns:

Rooting Reflex: Y N
Cheeks

Grasp Reflex: Y N
Palms of hands

Moro Response: Y N
Loud noises

Sleeping *(# of hrs/day):* _____

Pooping *(# of times/day):* _____

Feeding: *# of times/day* _____
Frequency:_____

_____
Doctor/Examiner Signature

_____/_____/_____
Date