PEDIATRIC CONFIDENTIAL HEALTH HISTORY

Please fill out the following information to the best of your knowledge to help us understand your child's condition fully and determine if we can help. All information provided is considered confidential and will only be released by written consent of patient or guardian of patient. Thank you for entrusting us with your care.

NAME_____ MALE/FEMALE DATE_____
ADDRESS_____CITY_____STATE_____ZIP_____
AGE_____ DATE OF BIRTH_____
HOME#_____CELL#_____ OTHER #_____
WOULD YOU LIKE APPOINTMENT REMINDERS? YES or NO IF YES, REMINDER PREFERENCE: TEXT or EMAIL
GUARDIAN_____ CELL/WORK #_____
EMERGENCY CONTACT_____ CELL/WORK #_____
HOW DID YOU HEAR ABOUT OUR OFFICE?_____

GENERAL HEALTH HISTORY

HEIGHT_____ WEIGHT_____ PEDIATRICIAN/PCP_____

HOSPITIALIZATIONS/ SURGERIES/OPERATIONS_____

PRIOR ACCIDENTS/INJURIES_____

ALLERGIES_____

CURRENT MEDICATIONS_____

CURRENT SUPPLEMENTS_____

RECENT IMAGING/TESTING (XRAY, MRI, CT scan, labs) within last year. Please provide date and body area:
_____

HAVE YOU BEEN DIAGNOSED WITH OR SUFFER FROM ANY OF THE FOLLOWING? ("x" what applies)

__CONSTIPATION/DIARRHEA	__ALLERGIES/SINUSES	__BED WETTING	__ OVER WEIGHT
__COLIC/REFLUX	__ASTHMA	__ MUSCLE PAIN	__NECK PAIN
__EXCESSIVE FUSSINESS	__FREQUENT SICKNESS	__JOINT PAIN	__HEADACHES
__EAR INFECTIONS	__ SLEEP ISSUES	__DIABETES	__LOW BACK PAIN
__ADD/ADHD	__DEVELOPMENT DELAYS	__SENSORY DISORDERS	__OTHER_____

Please explain any of the above checked symptoms _____

_____

_____

[CONTINUED ON BACK PAGE]

PRENATAL HISTORY

LOCATION OF BIRTH _____

DELIVERY (circle which apply) Vaginal or CSection Epidural or No Epidural Natural Labor or Enduced Labor

Vacuum/Forcep Extraction Fetal Distress during labor Special Procedures

Describe any complications during pregnancy or birth _____

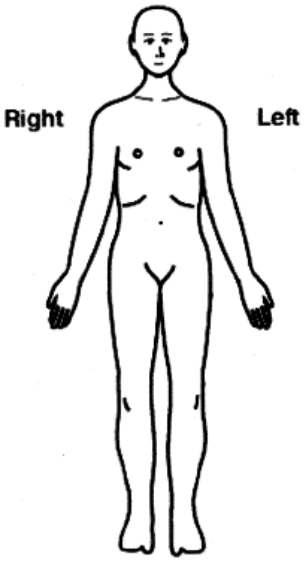
_____

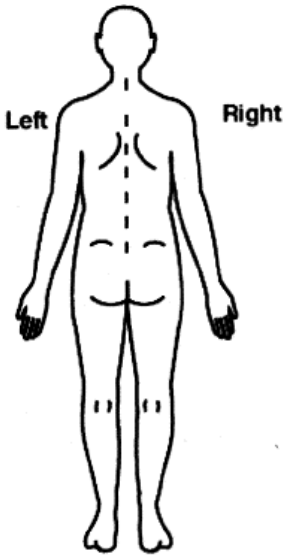
FEEDING (circle which apply) Exclusively Breastfed Exclusively Formula Fed Breastfed/Formula Fed

REASON FOR VISIT (please describe complaint(s) in detail and in order of severity and importance)

1._____
2._____
3. _____

WHEN DID THIS CONDITION(S) START?_____
ARE YOU UNABLE TO DO ANY ACTIVITIES?_____ IF YES, EXPLAIN_____
DO YOU KNOW WHAT CAUSED THIS?_____
HAVE YOU BEEN TREATED FOR THIS PROBLEM?(when/where)_____
_____IF SO, DID THE TREATMENT HELP?_____





PAIN SCALE

Please circle the level that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

MILD MEDIUM SEVERE

Draw an "X" on the diagram to the left in the area of your complaint(s) and a letter describing

A=achy
B=burning
S=stabbing
N=numbness
T=tingling

_____

PARENT/GUARDIAN SIGNATURE DATE

SOUTHALL CHIROPRACTIC, PLLC

POLICIES AND INFORMED CONSENT

PAYMENT FOR SERVICE: Payment is due at the time of service by Cash, Check, Debit/Credit/HSA Card. There will be a 4% transaction fee on all card purchases.

INSURANCE: We are currently not in network with any form of commercial health insurance. We will gladly provide a receipt with coding to patient to file claims their selves. Please allow 2-3 business days to receive courtesy receipt.

ADDITIONAL FEES: : A no call/no show fee of $30 will be charged to any patient who does not cancel their scheduled appointment within 12 hours of appointment time. Acceptable forms of cancellation are by telephone or responding to text message reminder day BEFORE appointment only. Unacceptable forms of cancellation are by email, text message, Facebook, or any other form of social media.

MEDICAL RECORDS: Any request for medical records by the patient will be mailed, faxed, or picked up in person. Please allow 10 days to receive these records or reports. There will be a $30 charge for 1st 10 pages of all medical records plus $1 for each additional page.

Patient/Guardian Signature:_____Date:_____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

SOUTHALL CHIROPRACTIC, PLLC

HIPPA

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

I have read and agree to the above policies and understand my right to protect my privacy.

Patient Signature:_____Date:_____

Please list names of family members and physicians we are ALLOWED to share your child's information with. If someone outside of this list contacts our office on your behalf, we will be unable to speak to them about you or allow them to schedule your appointments.

Name_____Phone Number :_____

Name_____Phone Number :_____

Please list any other adults who are allowed to bring your child to their appointments. If someone outside of this brings your child to their appointment, we will be unable to see your child without prior authorization.

Name_____Phone Number :_____

Name_____Phone Number :_____