PEDIATRIC HISTORY FORM (ages 6 and under)

CONFIDENTIAL PATIENT INFORMATION: **DATE:** ____________________

CHILD'S NAME: ______________________________ DOB: __________ AGE: ________ Gender: ______

ADDRESS: ______________________________ CITY: ____________ STATE: ______ ZIP CODE: ____________

MOTHER'S NAME: ______________________________ HOME PHONE: ____________________

FATHER'S NAME: ______________________________ ALTERNATE PHONE: ____________________

PARENT'S SOCIAL SECURITY NO: ____________________ PCP NAME(of CHILD): ____________________

WHO IS RESPONSIBLE FOR THIS ACCOUNT?: ____________________ REFERRED BY: ____________________

Do you have health insurance for this child?: ________ Ins Company?: ____________________ Policy#: ____________________

Name of employee: ____________________ Employee's SS#: ____________________ Employer: ____________________

I hereby authorize Dr. Bailey and whomever she may designate as her associate to administer chiropractic care as she deems necessary. Nearly all insurance policies provide chiropractic coverage, but benefits vary for each company/policy. Therefore, if we have insurance that the Chiropractic Family Health Center accepts, we will utilize their billing service. I will be personally responsible for payment of all services not covered by our insurance. X-rays remain the property of this clinic.

______________________________ ______________________________

Signature of parent or guardian Relationship to child

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

PATIENT CASE HISTORY:

Purpose for this appointment: ______________________________

Other doctors seen for this condition and the treatment provided: ______________________________

____

Family history: ______________________________

Previous chiropractor: ______________________________ Date of last visit: ____________________

Name of pediatrician: ______________________________ Date of last visit: ____________________

Number of doses of antibiotics your child has taken in the last six months: ____________ during lifetime: ____________

Number of doses of other prescription medications your child has taken during the last six months: ____________

Total during his/her lifetime: ______________ List prescriptions: ______________________________

Vaccination history: ______________________________

Check any of the following conditions your child has experienced:

_____ADHD	_____ Digestive problems	_____Recurring fevers
_____Asthma/Allergies	_____ Ear infections	_____Scoliosis
_____Bed wetting	_____Growing/back pains	_____Temper Tantrums
_____Chronic colds	_____Headaches	_____Other
_____Colic	_____Hyperactivity	_____Other

enatal History:

ame of obstetrician/midwife:______________________________

omplications during pregnancy?: _____Y _____N, List:______________________________

trasounds during pregnancy?:_____Y_____N How many?:________

edications during pregnancy/delivery?:_____Y_____N, List:______________________________

garette/alcohol/drug use during pregnancy?:_____Y_____N

ocation of Birth?:_____hospital_____birthing center_____home delivery

rth intervention?: _____forceps _____vacuum extraction _____breech birth

_____caesarian section, _____emergency, or_____ planned

omplications during delivery?:_____Y_____N, List:______________________________

enetic disorders or disabilities?:_____Y_____N,List:______________________________

rth weight:__________Current weight:__________Birth length:__________APGAR scores:________,________

undice (yellow):Y_____N_____ Cyanosis (blue):Y_____N_____

eeding History:

east fed:_____Y_____N, How long:__________ Formula fed:_____Y_____N, How long:__________

troduced to solids at ________months. Introduced to cows' milk at _____months.

od/Juice allergies or intolerances:_____Y_____N, List:______________________________

evelopmental History:

uring the following times your child's spine is most vulnerable to stress and should routinely be checked by a ctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At hat age was your child able to:

__________Respond to sound
__________Respond to visual stimuli
__________Hold head up
__________Sit up
__________Cross crawl
__________Stand alone
__________Walk alone

ccording to the National Safety Council, approximately 50% of children fall head first from a high place during eir first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?:____Y____N

as your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, eerleading, martial arts, etc.)?:_____Y_____N, List:______________________________

as your child ever been involved in a car accident?:_____Y_____N, List:______________________________

her traumas not described above?:_____Y_____N, List:______________________________

ior surgery:_____Y_____N, List:______________________________

PLEASE DO NOT WRITE IN THE SPACE BELOW

Chiropractic Family Health Center
Dr. Kimberly J. Bailey/Dr. Isaiah R. Stephan
PO Box 8120 138 Halifax Street
Winslow, Maine 04901

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices

I, ______________________________________, acknowledge that I have been given the opportunity to read the *Chiropractic Family Health Center's,* Notice of Privacy Practices located in the reception area.

Signature:______________________________________Date:____________________________

Consent to Care

I,______________________________________, permit Dr. Kimberly J Bailey and whomever she designates as her associate to administer chiropractic care as she deems necessary. Chiropractic benefits may be covered by my insurance, but I know that I am personally responsible for payment of services rendered. I have received information about risks and benefits involved in the evaluation of my condition and recommended treatments.

Signature:______________________________________Date:____________________________

CONSENT TO X-RAY (PARENT AUTHORIZING XRAYS ON A MINOR CHILD)

I, ______________________________________authorize Dr. Kimberly Bailey or her associate to take any x-rays necessary for diagnosis and treatment of __________________________(minor's name).

Signature:______________________________________Date:____________________________

PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I UNDERSTAND I AM RESPONSIBLE FOR PAYING ALL COSTS ASSOCIATED WITH MY EVALUATION AND CARE. If I have health insurance, I understand I am financially responsible in the event all or some payment is denied by my insurance carrier. **I am also responsible for those charges not covered by my insurance as deductible, co-pays and any other treatment that are not included as an insurance benefit.**

I authorize my health insurance carrier(s) or third parties that are responsible for paying for my health care to pay costs associated with my evaluation and care directly to the Chiropractic Family Health Center. **This is a direct assignment of my rights and benefits under this policy.** A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the Chiropractic Family Health Center to appeal any unfavorable payment decisions on my behalf. I further authorize the release of any information pertinent to the appeal to the insurance company involved in this case. I authorize the Chiropractic Family Health Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature:______________________________________**Date:**____________________________

INFORMED CONSENT

Chiropractic doctors who perform manipulation are required by law to obtain your informed consent before starting treatment.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I understand that in very isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning.

Tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Reasonable alternatives to these procedures have been explained to me. I understand that neglecting care may have potential risks that may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology, as well as a lowered immune system leading to disease.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.