

Dilworth Chiropractic AND WELLNESS CENTER

Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build a better health for your family.

Patient Name: _____ S.S.# _____
Address: _____ City: _____
State: _____ Zip: _____ Birth Date: ____/____/____ E-mail _____
Home Phone: _____ Cell: _____ Work Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred by: _____
Names of Parents / Guardians: _____

Purpose For Contacting Us? _____
Other Dr's seen for this condition: _____
Prior treatments given for this condition: _____
Other Health Concerns: _____

Check any of the following conditions your child has suffered from in the past six months:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Growing/Back Pains | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Car Accident |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Bed Wetting | | |
| <input type="checkbox"/> Other _____ | | | |

Previous Chiropractor: _____ Date of Last Visit _____
Name of Pediatrician: _____ Date of Last Visit _____
Reason for Visit: _____

Are You Satisfied With The Care Your Child Has Received? ___ No ___ Yes

Number of Doses of Antibiotics Your Child Has Taken: _____ Last 6 Months ___ Life

Vaccination History? _____

CHILDHOOD DISEASES

Chicken Pox	Yes: _____	No: _____	Age: _____	Rubeola	Yes: _____	No: _____	Age: _____
Rubella	Yes: _____	No: _____	List: _____	Mumps	Yes: _____	No: _____	Age: _____
Whooping Cough	Yes: _____	No: _____	List: _____	Other	Yes: _____	No: _____	Age: _____

Prenatal History:

Name of Obstetrician / Mife: _____
Complications During Pregnancy? ___ No ___ Yes, List _____
Ultrasounds During Pregnancy? ___ No ___ Yes, Number _____
Medication During Pregnancy? ___ No ___ Yes, List _____
Cigarette / Alcohol Use During Pregnancy? ___ No ___ Yes

Type of Birth: (check all that apply)

___ Normal Vaginal ___ Epidural ___ Forceps ___ Suction ___ Breech
___ Cesarean
___ Home Birth ___ Hospital Birth
___ Birth Weight ___ Birth Length ___ APGAR Scores: _____; _____

Feeding History:

Breast Fed: ___ No ___ Yes, How Long? _____
Formula Fed: ___ No ___ Yes, How Long? _____ Type? _____

Allergies/intolerance Yes: _____ No: _____ List: _____

DEVELOPMENTAL HISTORY

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

___ Respond to sound ___ Hold Head Up ___ Cross Crawl ___ Walk Alone
___ Respond to Visual Stimuli ___ Sit Up ___ Stand Alone _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie, bed, changing table, down stairs, etc).

Was this the case with your child? Yes: ___ No: ___ List: _____

Is/has your child been involved in any high impact or contact type sports (ie, soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)?

Yes: ___ No: ___ List: _____

Has your child ever been involved in a car accident? Yes: ___ No: ___ List: _____

Have your child been seen on an emergency basis? Yes: ___ No: ___ List: _____

Other traumas not described above? Yes: ___ No: ___ List: _____

Prior surgery? Yes: ___ No: _____

Menarche? Yes: ___ No: ___ List: _____

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

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Date: _____

Signature On File

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my insurance companies.
- I authorize that I am responsible for my bill.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Insurance Information

Insurance Company: _____ Policy #: _____
Policyholder Name (if not same as patient) _____ Date of Birth _____

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801 E Morehead St, Suite 306 PO Box 30847 Charlotte, NC 28202
704-370-3701 704-370-3702 FAX

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may disclose your examination, treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in your care or to facilitate the payment related to your care.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b) (1) (iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you as a result of a Workers' Compensation injury.
3. If you are/were a member of the armed forces, as we are required by military command authorities to release your health information.
4. If we provide health care services to you as an inmate.
5. If we provide health care services to you in an emergency or disaster relief situation.
6. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*Other than the circumstances described in the above examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(i)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

Dilworth Chiropractic & Wellness Center
PO Box 30847
Charlotte, NC 28230-0847

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Dr. Sonia Stryker, Chiropractic Physician

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Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services we provide at a place other than your home, or if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- *Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- *Those disclosures made to you.
- *Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- *Those disclosures for national security or intelligence purposes.
- *Those disclosures made to correctional officers or law enforcement officers.
- *Those disclosures that were made prior to the effective date of the HIPAA privacy law.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

To Contact us

If you would like further information about our privacy policies and practices please contact:

Dilworth Chiropractic & Wellness Center
801 E Morehead St #306
Charlotte, NC 28202
(704) 370-3701

For more information or to Report a Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer:

Dr. Sonia Stryker at (704) 370-3701

If you believe your privacy rights have been violated, you can either file a complaint with this office or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR.

The address for the OCR regional office for North Carolina is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3870
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy of this authorization at my request. This notice is effective as of June 22, 2006. This authorization will expire seven years after the date on which you last received services from us.

Patient Name Printed

Patient Signature

Date

Witness Signature

Dr. Sonia Stryker, Chiropractic Physician

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Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by Sonia Stryker, DC and/or other licensed Doctors of Chiropractic who now or in the future work at Dilworth Chiropractic & Wellness Center.

I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office helps reduce the possibility of the below risks, but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible 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 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 Name Printed

Date

Patient Signature

Parent/Guardian's Signature

DO NOT WRITE IN THIS BOX

Patient Accepted? YES NO Doctor's Signature_____

Dr. Sonia Stryker, Chiropractic Physician