Pediatric Health History

Welcome to Vinings Family Chiropractic & Wellness

To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family. Please print clearly filling this out completely prior to your appointment time.

Patient Information

Date: _____ Male/Female (circle one)

Name:_____

Nickname:_____

Birth date: _____ Age:_____

Social Security # _____

Address:_____

City:_____ State:_____Zip:_____

Contact Information

Parents Name (s):_____

Home Phone: _____

Mom Cell Phone:_____

Dad Cell Phone:_____

Parent's Email Address
(for patient newsletter and office information)
_____@_____

Whom May We Thank for Referring Your Child? _____

Health Information

Please check reasons for pursuing chiropractic care for your child:

__ She/He is continuing ongoing care form another chiropractor.

__ I recently had my spine checked and I see the value in getting my child checked.

__ I'm concerned about his/her health and I'm looking for answers.

__ I want to improve my child's immune function.

__ I have no idea why we're here. Please take the time to explain to me what you do for children.

__ She/ He has a specific condition that concerns me.
Explain condition or symptom:
_____
_____
_____
_____
_____

Insurance

Does your child have Health Insurance?.....Yes / No
Company _____
Policy# _____
Group# _____

Who is the Primary Insured?
Name _____
Company_____
Policy#_____

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously.

__ Headaches __ Postural Imbalance __ Asthma

__ Allergies __ Ear Infections __ Scoliosis

__ ADD/ADHD __ Autism __ Seizures

__ Bedwetting __ Sinus Problems __ Colic

__ Growing/ Back Pains __ Car Accident

__ Digestive Problems __ Frequent Colds

__Other:_____

Health History

Has your child ever seen a chiropractor before?_____ Approximate last date adjusted?_____

Names of other doctors who have cared for you: _____

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan:_____

Medications and Supplements your child is taking:

_____

_____

Number of rounds of Antibiotics taken: During last 6 months: _____ In Lifetime:_____

Reasons:_____

Number of rounds of Other Prescription Medications Taken: During last 6 months: _____ In Lifetime:____

Reasons:_____

Prenatal History

Adopted? ___No ___ Yes

Complications during pregnancy? ___No ___Yes List:_____

Complications during delivery? ___No ___Yes List:_____

Birth Intervention: ___ Mother Medicated (Pitocin, etc.) ___ Caesarian Section ___Forceps

___ Vacuum Extracted ___ Emergency

Genetic Disorders or Disabilities? ___No ___Yes List:_____

Trauma History

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a 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 (i.e. soccer football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? ___No ___Yes

List:_____

Has your child been seen on an Emergency Basis? ___No ___Yes

List:_____

Has your child ever had surgery? ___No ___Yes List:_____

Has your child ever been involved in a car collision? ___No ___Yes List:_____

Other traumas not described above? List:_____

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

AUTHORIZATION FOR CARE OF MINOR

I herby 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 charge by this office.

Parent Signature_____ **Date**_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information. A complete copy of this document is available upon request.

Parent Signature_____ **Date**_____

- I give permission to use my child's photo in the office as witness and celebration of my wellness.
- I give permission to use my child's name in the office if I refer a new member to the practice.
- I understand that if my child is chosen as Patient of the Week, I give permission for certain information about my child's case to be disclosed within the office.
- If I choose to give a testimonial of my child's experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

Parent Signature_____ **Date**_____

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associates. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

_____ _____

Signature of Patient Printed Name of Patient

PAYMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Vinings Family Chiropractic & Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I also understand that if I accumulate an account balance I am responsible for paying it in full within 30 days, otherwise my account will be charged a $15 late fee and this balance will be subject to a 15% interest rate until the balance is brought to $0. Returned checks are subject to a fee of $25. If any balance goes more than 60 days overdue, the credit card I have on file will be charged the remaining balance.

_____ _____

Signature of Patient Printed Name of Patient

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

***Adjustment*: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.**

***Health*: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.**

***Vertebral Subluxation*: A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.**

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY PRACTICE OBJECTIVE*** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

I understand if I have any questions I am able to ask the doctors, their associates and staff.
I, therefore, accept chiropractic care on this basis.

_____ _____

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Signature Date