TOUR ☐ DAY 1 EDUCATION ☐ EXAM ☐ XRAY/CLOSE ☐ PLATINUM # _____

# IMPACT FAMILY CHIROPRACTIC
# PEDIATRIC HISTORY FORM

## PATIENT DEMOGRAPHICS HR#:_____

Today's Date _____/_____/____

Childs Name_____

Date of Birth _____/_____/_____ Age: _____

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

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Parent Email: _____

Pediatrician/Family MD _____City/State _____

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

Who is responsible for this bill? _____

□ Father's Social Security #_____-_____-_____ □ Mother's Social Security #_____-_____-_____

□ 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***

_____

_____

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?: If yes, describe:

_____

4. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

_____

5. How long ago? _____Days _____Weeks _____Months _____Years

6. What were the results of 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 an injury playing organized sports? ___ No ___ Yes If yes; please explain:

_____

_____

_____

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

_____

_____

_____

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

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

□ Allergies to_____

□ Other: _____

I understand that I am directly and fully responsible Impact Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

□ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

**Notice of Privacy Practices Acknowledgement**

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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.

**Permitted Disclosures**:

- Treatment purposes – discussion with other health care providers involved in your care
- 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
- For payment purposes – to obtain payment from your insurance company or any other collateral source
- For worker's compensation purposes – to process a claim or aid in investigation
- Emergency – in the event of a medical emergency, we may notify a family member
- 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
- To governmental agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person
- For military, national security, prisoner, and government benefits purposes
- Deceased persons – discussion with coroners and medical examiners in the event of a patient's death
- Telephone calls or emails and appointment reminders – we may call your home/cell and leave voice/text messages regarding an appointment, a missed appointment, or notify you of changes in practice hours or upcoming events
- Announcing names in queue at the front desk & reception area – we announce the first and last names of patients in queue that are waiting to be treated (ex. "Jane Smith, please proceed to room 2"). Please notify the office manager if you would like this to be changed
- Change of ownership – in the event this practice is sold, the new owners would have access to your Personal Health Information

**Your rights**:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive Detail Privacy Notice
- To request mailings to an address different than residence
- To request restrictions 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.

**Terms of Acceptance**

In order to provide the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is essential for both parties to be working toward the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes is called a neuro-structural shift.
- 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 a day with doctors of chiropractic in the United States alone.
- 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.

**Informed Consent For Chiropractic Care**

Chiropractic Care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is often very minimal. Yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, and if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

By signing below:

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Dr. Aaron Cain. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

*Print Name*_____ *Signature*_____*Date*_____

**If this health profile is for a minor/child, please fill out and sign below.**

*Name of Practice Member Who is a Minor/Child:*_____

I authorize Dr. Aaron Cain, and any and all Impact Family Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Impact Family Chiropractic.

*Print Name*_____ *Signature*_____*Date*_____

**We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below.**

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Impact Family Chiropractic, or anyone authorized by Impact Family Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Impact Family Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Impact Family Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

*Signature*_____ *Date* _____

**X-Ray Authorization**

As your health care provider, Impact Family Chiropractic is 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-rays. The fee for the copy is $15 and must be paid in advance. Digital x-rays on a 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 doctors of Impact Family Chiropractic do not diagnose or treat medical conditions. However, the doctors will refer questionable x-ray films to be interpreted by a radiologist hired by Impact Family Chiropractic. The radiologist will submit a report of their interpretation to Impact Family Chiropractic, and if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, I am agreeing to the Notice of Privacy Practices Acknowledgement, Terms of Acceptance, X-Ray Authorization, and all the terms and conditions above.

*Print Name*_____ *Signature*_____*Date*_____

***Female Patients Only:***
To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time x-rays are taken at Impact Family Chiropractic.

*Print Name*_____ *Signature*_____*Date*_____