providence CHIROPRACTIC

Pediatric Health History

Child's Name: _____ Date: _____

Birth Date: _____ Age: _____ Sex: _____

Parents'/Guardians' Name: _____

Home Address: _____

Home Phone: _____

Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

Parent's Work Phone: _____ May we leave a message? ☐ Yes ☐ No

Parent's Email: _____ May we leave a message? ☐ Yes ☐ No

How did you hear about us? _____

Siblings and ages: _____

Has your child received previous chiropractic care? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship to Child: _____

Phone Number: _____ Alternative Phone Number: _____

Family Doctor

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and Reason of Last Visit: _____

May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Message Therapist, etc)

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and Reason of Last Visit: _____

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and Reason of Last Visit: _____

Why have you decided to have you child evaluated by a Chiropractor?

- ☐ He/She is continuing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I am looking for answers.
- ☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

Wellness Profile on next page – PLEASE READ

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called **vertebrae**. Many of the common health challenges that adults experience have their origins during the **development years**, some starting at birth. Layers of damage to the spine and **nervous system** occur as a result of various **traumas, toxins, and emotional stress**. The result may be misalignment to the spinal column and damage to the nervous system, a condition called **Vertebral Subluxation**. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal.

_____ initial

What signals has your child's body been communicating?

Current	Previous		Current	Previous		Current	Previous	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches / Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

☐ None of above, I would like my child's nervous system assessed to achieve optimal health & functioning. (skip "Health Concern section)

LIST YOUR HEALTH CONCERNS BELOW

	Health Concerns: *List according to severity*	**If Pain,** *Rate of Severity* 1 = mild 10 = unbearable	**When did** *this episode* **start?**	**If your child has** *had the condition* **before, when?**	**Any medication** *for this condition?*	**Any other** *treatment* **received for this?**
1.						
2.						
3.						
4.						

HAVE YOU EVER SEEN OTHER HEALTH PROFESSIONALS FOR THESE CONDITIONS? _____

PLEASE LIST MEDICATIONS/TREATMENT RECEIVED: _____

_____

Birth Experience (Please complete to best of your knowledge)

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other: _____

Medications during labor/delivery (including IV antibiotics): ☐ No ☐ Yes: _____

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Was you child at any time during pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following intervention used? ☐ Forceps ☐ Vacuum Extraction ☐ Other

If yes, please specify: _____

How long was labor from the first regular contractions to birth? _____ hours.

How long was the second stage (the pushing phase) of the labor? _____ hours.

Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes

Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

If known, APGAR scores as: 1 minute: _____/10 5 minutes: _____/10

Was the baby ever admitted to the NICU? ☐ No ☐ Yes

If yes, for how long and why? _____

Was any medication given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? ☐ No ☐ Yes ☐ Months: _____

Did your child show any sensitivities to formula? (reflux, eczema, arching back) ☐ No ☐ Yes

What age did you introduce solid foods to your child? _____ months

Did your child spend a lot of time in any baby devices

☐ No ☐ Yes Which types? (circle) BOUNCY SEATS SWINGS BUMBOS CAR SEATS JUMPERS OTHER

Physical Traumas

Has your child ever fallen from any high places?	☐ No ☐ Yes
Has your child ever been involved in a motor vehicle accident?	☐ No ☐ Yes
Has your child broken any bones?	☐ No ☐ Yes
Has your child had any previous hospitalizations?	☐ No ☐ Yes
Has your child had any previous surgeries?	☐ No ☐ Yes
Does your child use a tablet, computer, or video game?	☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day
Does your child watch TV?	☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day
Does your child exercise?	☐ No ☐ Daily ☐ Weekly ☐ Seasonally
Does your child play contact sports?	☐ No ☐ Daily ☐ Weekly ☐ Seasonally
Does your child sleep on their	☐ Back ☐ Belly ☐ Sides (both, right, left)
Does your child carry a back pack?	☐ No ☐ Yes
Does it weigh less than 15% of their body weight?	☐ No ☐ Yes
Do they wear their back pack on 2 shoulders?	☐ No ☐ Yes
Does your child's shoes show excessive or uneven wearing out?	☐ No ☐ Yes
Does your child wear custom orthotics?	☐ No ☐ Yes

If yes, for what purpose? _____

Do you feel your child developmentally appropriate for their age?

Intellectually: ☐ Yes ☐ No _____

Emotionally: ☐ Yes ☐ No _____

Physically: ☐ Yes ☐ No _____

Practice Member Information (Must be Completed before Services Can Be Rendered)

NAME: _____

FIRST MIDDLE LAST

PHONE: Home: _____ Cell: _____ Work: _____

SOCIAL SECURITY NUMBER: _____ MARITIAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation-Includes practice member history. This service is complimentary.**
- **Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and /or static palpation, leg checks $50-$75.**
- **Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.**
- **X-Rays-Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can be used to indicate progress after a period of care. $40 per view.**
- **Video Fluoroscopy- A radiographic spinal motion study performed in combination with x-rays to determine a misalignment/subluxation. This may be used to indicate progress after a period of care. $150 for full study.**

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jessica Harden, DC. 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.

Signed_____ Date_____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. 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 procedures applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. 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.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed and carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____
(Signature) (Date)

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 MOST 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 CHIROPRACTIC 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, OR IS ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IS 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.

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.

_____
PRINT PATIENT'S NAME HERE

_____ _____
PATIENT'S SIGNATURE DATE

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. JESSICA HARDEN AND ANY AND ALL PROVIDENCE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. OF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY PROVIDENCE CHIROPRACTIC.

_____ _____
DATE GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD

_____ _____
WITNESS SIGNATURE (OFFICE STAFF) DATE