#______

Pediatric History Form

Date: ________________

Patient Name: ____ SS#:______________________________Age: ________

Name of Parent/Guardian: ____ Phone#:_________________________________

Address: ____ City: ______________________State:______ Zip: ___________

Sex: Male/Female Height: _____________ Weight: ____________ Date of Birth: ______________________

I would you like Text/ Email reminders Yes / No Email: ____

Phone carrier? _____________________ How did you hear about us? _____________________________________

Reason for seeking care: ____

Other Doctors seen for this condition: ____

Other health problems: ____

Circle any of the following conditions your child has experienced in the last 6 months:

Ear Infections	Seizures	ADHD/ADD	Headaches	Anger Issues
Asthma	Bed Wetting	Chronic Colds	Back Pain	Sleeping problems
Allergies	Digestion Issues	Recurring Fevers	Neck Pain	Other:
Colic	Scoliosis	Growing Pains	Temper Tantrums	________________

Medication taken in the last year: ____

Previous Chiropractor: ____

Name of Pediatrician: ____

Is your child currently taking: Antibiotics? Yes/No Prescription Drugs? Yes/No

Has your child been vaccinated? Yes/No If yes, which ones: ____

Do you have insurance? Yes / No ***If yes, Please give your card to the front desk***

Doctor's Notes Only

Daily:	______	**Initial:**	____	**Fup:**	____
4xs:	______	**Cerv:**	____	**FupXr:**	____
3xs:	______	**Thor:**	____	**Traxn:**	____
2xs:	______	**Lum:**	____	**Exer:**	____
1x:	______	**ADJ:**	____	**Extrm:**	____
E-O:	______				
Mth:	______				

Prenatal History:

Complications during pregnancy:____

Ultrasounds during pregnancy: If yes, how many: ____

Medications taken during pregnancy/delivery: ____

Supplements taken during pregnancy: ____

Cigarette/Alcohol use during pregnancy: If yes, how often: ____

Location of birth: Hospital Birthing Center Home

Birth interventions: Forceps Vacuum Extraction Caesarian Section Epidural None

Complications during delivery: ____

Genetic disorders or disabilities: ____

Birth Weight: ___________ Birth Length: ______________

Breast Fed: Yes/No How long: __________________ Formula Fed: Yes/No How long:_____________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie: bed, changing table, downstairs, etc.) Was this the case with your child? If yes, Please describe:

____

Has your child been involved in any high impact or contact sports? (ie: soccer, football, gymnastics, baseball, martial arts, etc.) If yes, which ones: ____

Has your child ever been involved in a car accident: ____

Other traumas not described above: ____

Surgeries: ____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and form to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to may account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand than agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be check if Clear Chiropractic extend credit to me and I understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and paid unless other arrangement are made. I hereby authorize the doctors and massage therapists at Clear Chiropractic and whomever they may designate as their assistants, to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Parent/Guardian Signature: ____Date:__________________

CLEAR Chiropractic
Notices of Privacy Practices

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

CLEAR Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example),

"On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with CLEAR Chiropractic"

"It is our policy to provide a substitute health care provider, authorized by CLEAR Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature of CLEAR Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

"As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to CLEAR Chiropractic for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received."

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health

As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity.We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of CLEAR Chiropractic sponsored fund- raising events."

Change of Ownership

In the event that CLEAR Chiropractic is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- *You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that CLEAR Chiropractic is not required to agree to the restriction you requested.*
- *You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.*
- *You have the right to inspect and receive a copy of your health information.*
- *You have the right to request that CLEAR Chiropractic amend your protected health information. Please be advised, however, that CLEAR Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.*
- *You have the right to receive an accounting of disclosures of your protected health information made by CLEAR Chiropractic*
- *You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.*

Changes to this Notice of Privacy Practices

CLEAR Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, CLEAR Chiropractic is required by law to comply with this Notice. (Continued)

(cont'd) CLEAR Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Angela Ritson by calling 425-820-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how CLEAR Chiropractic has handled your health information should be directed to Angela Ritson by calling 425-820-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201

This notice is effective as of (01/14/2010)

I have read the Privacy Notice and understand my rights contained in the notice

By way of my signature, I provide CLEAR Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print) ______________________________

______________________________ ______________________________

Patient Signature **Date** **Guardian Signature** **Date**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care 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 be specific adjustments 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 alteration 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 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 subluxations.

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

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

Patient Name (please print) ______________________________

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Patient Signature **Date**

Pain Index Questionnaire

In the last (week/month),

How many days did your child *miss school* due to (this health problem)? .... __

How many days did you *reduce their normal activities* due to (this health problem)? .... __

How many days did they *stay in bed more than half a day* due to (this health problem)? .... __

How many days have they felt very healthy and full of energy? .... __

Global Well Being Scale

Please think about your child's general sense of health and well-being. On the line below, make a straight line (up-and-down) to show how they feel right now.

WORST YOU COULD POSSIBLY FEEL |————————————| **BEST YOU COULD POSSIBLY FEEL**

Numeric Rating Scale

On a scale of 0 to 10, where "0" is "no pain" and "10" is the worst pain imaginable, please check the number that represents their pain right now.

NO PAIN ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 **WORST PAIN**

Specific Activities

(use activity limitation scale for each one.)

Are there activities they can't do or have trouble doing due to this health concern? Please list. (examples: breastfeeding, sleeping, eating, crawling, walking, playing, going to school, etc.)

______________________________________ ______________________________________

Activity Limitation

How much did this health concern **limit** their daily activities **in the last week**?

Activities are not limited ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 Can't do daily activities at all

Global Perception of Change

Check the **one** number that best describes how their health problem is now, compared with how it was before you started treatment.

very much better	much better	a little better	no change	a little worse	much worse	very much worse
❑1	❑2	❑3	❑4	❑5	❑6	❑7

Patient Name (please print) ______________________________________

______________________________________ ______________________________________

Patient Signature **Date** **Guardian Signature** **Date**