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

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

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 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:

_____

_____

_____

11. Birth and infancy – the birth process can traumatize a baby's spine and cause damage to the spine & nervous system. Please CHECK where and how child was born.

☐Home ☐Natural ☐Hospital ☐Caesarian section ☐Cord around neck
☐Breech ☐Forceps ☐Suction ☐Drug induced ☐Prolonged labor

**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 to Restoration 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

restoration CHIROPRACTIC

# Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Restoration Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY** → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

If pregnant, Due Date: _____ N/A Name of OBGYN or Midwife _____

Where will you be birthing your baby? ☐Hospital ☐Home ☐Birthing Center ☐Other_____

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

# RESTORATION CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. 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. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean 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.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. 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.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. 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.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Dr. Jessica Gault at (316) 444-0168 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

*Patient initials:* **_____-retaining *page 1 of 2***

## *RESTORATION CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…*

I have received a copy of Restoration Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

| Patient's Name | DOB | HR# |
|---|---|---|

| Patient's Signature | Date |
|---|---|

| Witness | Date |
|---|---|

# *Medical Information Release Form*
# *(HIPAA Release Form)*

**Name:** _____ **Date of Birth:** _____

***Release of Information:***
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages:***
Please call [ ] my home [ ] my work [ ] my mobile number: _____

Text Message Reminders [ ] yes [ ] no mobile phone carrier: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____