PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____ DOB:_____

Case Number:_____ Father's Name:_____ DOB:_____

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Mother's Cell Phone:_____

Email:_____ Father's Work Phone:_____ Father's Cell Phone:_____

Birth Date:_____ _____ _____ Age:_____ Sex:_____ Number of Siblings:_____ Referred by:_____

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Apgar Scores:_____ _____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects?_____ If Yes, Please Explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, Which Formula? _____

Number of Hours Sleeping per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor _____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During the past six months_____ During his/her lifetime_____

Previous Chiropractor:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Has your child ever been treated on an emergency basis?_____ If yes, please explain:_____

Purpose of this Appointment:_____

Insurance/Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED:_____ WITNESSED: Daley Booke DATE_____ _____ _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:_____ DATE_____ _____ _____

PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

☐ 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	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Diabetes	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Anemia	☐ Other_____
☐ Colic	☐ Broken Bones	☐ Bed Wetting	☐ Other_____

Has this child ever suffered the following spinal traumas?

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____

Hornstein Family Chiropractic
715 Dakota Avenue, Suite 2 – Wahpeton, ND 58075 – 701-672-1300

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

IF THE PATIENT IS A MINOR THE PARENT MUST SIGN ABOVE!