CRANBERRY FAMILY CHIROPRACTIC - PEDIATRIC HISTORY FORM

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS:

Child's Name: _____ DOB: _____ Age: _____ ❑ M ❑ F
Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____
Mothers Name: _____> Mobile: _____ DOB: _____
Father's Name: _____> Mobile: _____ DOB: _____
Pediatrician/Family MD: _____ City & State: _____ Last Visit: _____
Who is responsible for the bill/financial: ❑ Father > Social Security#: _____ OR
❑ Mother > Social Security#: _____ OR ❑ Other (please explain): _____

CHILD'S CURRENT COMPLAINT:

1. Purpose of visit: ❑ Wellness Check-up ❑ Injury or Accident ❑ Other > Please explain: _____
2. If your child is experiencing pain/discomfort, please identify Where: _____ How long: _____
3. When did this complaint first begin (date): _____ ❑ Unknown ❑ Gradual ❑ Sudden
4. Ever had this complaint before? ❑ No ❑ Yes – If yes, When? _____
5. Any bowel or bladder problems since this complaint began? ❑ No ❑ Yes – If yes, Describe: _____
6. Have you seen any other doctors for this complaint? ❑ No ❑ Yes – If yes, Who? _____
   How long ago? _____ Days _____ Weeks _____ Months _____ Years
   What were the results of past treatments? _____
7. How is this complaint NOW? ❑ Rapidly Improving ❑ Improving Slowly ❑ About the Same ❑ Gradually Worsening ❑ On & Off
8. Please list any medications taken for this complaint: _____
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 from an auto accident? ❑ No ❑ Yes – If yes, please explain: _____

CHILD'S PAST HISTORY: Has your child ever suffered from….*(check all that apply)*

❑ Headaches	❑ Orthopedic Problems	❑ Digestive Disorders	❑ Behavioral Problems	❑ Dizziness
❑ Neck Problems	❑ Poor Appetite	❑ ADD/ADHD	❑ Arm Problems	❑Fainting
❑ Stomach Aches	❑ Ruptures/Hernia	❑Seizures/Convulsions	❑ Leg Problems	❑ Reflux
❑ Muscle Pain	❑ Heart Problems	❑ Joint Problems	❑ Growing Pains	❑Constipation
❑ Chronic Earaches	❑ Backaches	❑ Diarrhea	❑ Allergies – to: _____	
❑ Sinus Problems	❑ Poor Posture	❑ Hypertension	❑ Asthma	❑ Scoliosis
❑ Anemia	❑ Colds/Flu	❑ Walking Problems	❑ Bed Wetting	❑ Colic
❑ Broken Bones	❑ Sleeping Problems	❑ Fall from Baby-Walker	❑ Fall from Bed or Couch	
❑ Fall from Crib	❑ Fall off Swing	❑ Fall off Bicycle	❑ Fall from High-Chair	
❑ Fall off Slide	❑ Fall down Stairs	❑ Fall from Changing-Table	❑ Fall off Monkey-Bars	
❑ Fall off Skateboard/Skates		❑ Other: _____		

INFORMED CONSENT FOR CHIROPRACTIC CARE:
REGARDING: FEES, CHIROPRACTIC ADJUSTMENTS, MODALITIES, & THERAPEUTIC PROCEDURES

I understand that I am directly and fully responsible to CRANBERRY 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

ACTIVITIES OF DAILY LIVING

(SYMPTOMS/MEDICATIONS)

CRANBERRY FAMILY CHIROPRACTIC

Patient Name: _____ Date: _____

Daily Activities: Effects of current conditions on performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the Past, C for Currently have, and N for Never:

___Headache
___Neck Pain
___Jaw Pain, TMJ
___Shoulder Pain
___Upper Back Pain
___Mid Back Pain
___Low Back Pain
___Hip Pain
___Pregnant (now)
___Dizziness
___Prostate Problems
___Ulcers
___Frequent Colds/Flu
___Loss of Balance
___Impotence/Sexual Dysfun.
___Heartburn
___Convulsions/Epilepsy
___Fainting
___Digestive Problems
___Heart Problem
___Shoulder Pain
___Tremors
___Double Vision
___Colon Trouble
___High Blood Pressure
___Chest Pain
___Blurred Vision
___Diarrhea/Constipation
___Low Blood Pressure
___Pain w/Cough/Sneeze
___Ringing in Ears
___Menopausal Problems
___Asthma
___Foot or Knee Problems
___Hearing Loss
___Menstrual Problem
___Difficulty Breathing
___Sinus/Drainage Problem
___Depression
___PMS
___Lung Problems
___Back Curvature
___Swollen/Painful Joints
___Irritable
___Bed Wetting
___Kidney Trouble
___Scoliosis
___Skin Problems
___Mood Changes
___Learning Disability
___Gall Bladder Trouble
___Numb/Tingling arms, hands, fingers
___ADD/ADHD
___Eating Disorder
___Liver Trouble
___Numb/Tingling legs, feet, toes
___Allergies
___Trouble Sleeping
___Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:

_____
_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICE

CRANBERRY FAMILY CHIROPRACTIC

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 to 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 complaints about how we handle your health information please call _____ at (_____) _____-_____. If she/he is unavailable, you may make an appointment with our receptionist to see her/him 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

NOTICE OF PRIVACY PRACTICE continued…

CRANBERRY FAMILY CHIROPRACTIC

I have received a copy of Cranberry Family Chiropractic's Patient 'Notice of Privacy Practice'. I understand my rights as well as the practices 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 any 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 (Printed)	DOB	HR#:
_____	_____	
Patient's Signature	Date	
_____	_____	
Witness's Signature	Date	