Child History Form

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Date : _____ Child's Name: _____ ( ) M( ) F DOB:_____ Age:_____

Mother: _____ Father: _____ Legal Guardian: _____

Best Phone: _____ ( ) cell ( ) Home SS NO.:_____-_____-_____

Address: _____City:_____Zip:_____

Email Address: _____@ _____.com

☐ Email or ☐ Text me appointment reminders: IF different # or email from above: _____

Who can we thank for referring you? _____

Pediatrician Name:_____ Last Appt Date: _____

Siblings? Names/ages: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____

What is your main reason for today's visit? ( ) Wellness Check - FYI: INSURANCE MAY DENY if no musculoskeletal issues

( ) Other: _____

_____

List any other care your child has undergone with regard to this complaint including medications:

_____

_____

Date of onset (mm/yyyy): _____ Onset was: ( ) Sudden ( ) Gradual ( ) Associated with an event

Duration of problem/episode: (Check one) Pattern of Problem: (Check one)

____ ( ) Minutes ( ) Hours ( ) Days ( ) Months ( ) Years ( ) Constant ( ) Intermittent ( ) Occasional ( ) Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body function and daily activities?

_____

Prior occurrence or episodes? _____

Other health concerns? _____

Any known allergies?

_____

HISTORY OF BIRTH

( ) Hospital ( ) Birthing Center ( ) Home ( ) MD/DO ( ) Midwife

Duration of Pregnancy: ____ Weeks **Birth Weight** _____ **Birth Length** _____ **Hours in labor**: _____

Was the birth assisted? ( ) Yes ( ) No If yes, how? ( ) Forceps ( ) Vacuum extraction ( ) C-Section ( ) Induced Labor

Were medications given to the mother at birth? ( ) Yes ( ) No If yes, what? _____

Was the delivery 'normal'? ( ) Yes ( ) Now If no, what were the complications? _____

Birth Position: ( ) Head first ( ) Breech ( ) Other: _____ APGAR at Birth ___/10 & after 5 minutes ___/10 □**UNKNOWN**

GROWTH AND DEVELOPMENT

Was the infant alert & responsive within 12 hours of delivery? ( ) Yes ( ) No If no, explain_____

Are there any apparent delays? _____

Are there any suspected delays? _____

Sleeps on his/her-*choose all that apply*: ( ) Back ( ) Stomach ( ) Right side ( ) Left Side ( ) Both sides ( ) Incline ( )Unknown

Describe any health problems that exist on the mother &/or fathers side of the family? (i.e. cancer, diabetes etc.)

_____

Do the child's siblings have any health problems? ( ) Yes ( ) No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

CHEMICAL STRESSORS

During pregnancy, did the mother: 1. Smoke ( ) Yes ( ) No 2. Drink alcohol? ( ) Yes ( ) No 3. Drink caffeine? ( ) Yes ( ) no

4. Take Rx/supplements? ( ) Yes ( ) No If yes, what? _____ 5. Become ill? If so, how? _____

6. Receive ultrasounds? ( ) Yes ( ) No If yes, how many? _____ 7. Receive invasive procedures (i.e. amniocentesis, CVS)? ( ) Yes ( ) No

8. Did Mother exercise during pregnancy? ( )No ( ) Yes 9. Was/IS your child breastfed? ( ) No ( ) Yes, for how long? _____

At what age was: Formula introduced? _____ Brand? _____ Cows milk?_____yrs/mos Solid foods? _____ yrs/mos

Did your child receive vaccinations? ( ) Yes ( ) No if yes, which ones? _____ Did your child react to them? ( ) Yes ( ) No

Has your child had antibiotics? ( ) Yes ( ) No If yes, how many & why? _____

Any pets at home? ( ) Yes ( ) No Any smokers at home? ( ) Yes ( ) No Childhood illnesses? ( ) Yes ( ) No _____

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? ( ) Yes ( ) No Any problems bonding? ( ) Yes ( ) No Avg # hours of TV/electronics per week _____hrs

Any behavioral concerns? ( ) Yes ( ) No if yes, explain_____

Does your child have difficulties sleeping ( ) Yes ( ) No If yes, explain: _____

TRAUMATIC STRESSORS

Any evidence of trauma during birth? ( ) Bruises ( ) Odd shaped head ( ) Stuck in birth canal ( ) Fast &/or excessively long birth ( ) respiratory depression ( ) cord around neck ( ) other _____

Any falls/accidents during pregnancy? ( ) Yes ( ) No Has the child had any major falls since birth ( ) Yes ( ) No If yes, did the child need stitches or obtain a fracture? Describe: _____

Any hospitalization's? ( ) Yes ( ) No Please explain:

_____

Is your child involved in any activities (Yoga; Tumbling, etc)? ( ) Yes ( ) No # Hrs/week? _____ Age child began _____

Signature of Parent or guardian: _____

Body Works Chiropractic Studio

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE BODY WORKS CHIROPRACTIC STUDIO TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____

DATED THIS ____ DAY OF _____, 20___

_____ _____

Patient's Signature Doctor's Signature

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____
DOB: _____
Printed name of person legally authorized to sign for
Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks:

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

Body Works Chiropractic Studio

I grant Body Works Chiropractic Studio and its employees the right to take photographs of me with connection to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Body Works Chiropractic Studio may use such photographs of me and for any lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

I am at least 18 years of age and have read and understand the above:

Signature_____
Printed Name_____

If under 18 years of age the legal guardian or parent has read and understands the above:

Signature_____

Printed
Name_____

Body Works Chiropractic Studio

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY
TIME.

In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health- record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment
and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be

addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.
All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer, Premier Wellness Chiropractic, 411 Congress Parkway, Suite C, Crystal Lake IL 60014

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____	_____	_____
Patient Name	**Patient Signature**	Date
_____	_____	_____
Name of Personal Representative	Signature of Personal Representative	Date

Legal Authority of Personal Representative: _____