# Pediatric Health History Form PT # _____

*Austin Wellness Chiropractic Center*
*10518 RR 2222 Bldg3C Unit #100 Austin Tx 78730 512-234-1868*

## Patient Information

Child's First Name: _____ Last Name:_____ Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Mother's Name:_____ Father's Name:_____
Phone #_____ Birth Date:_____ Age:_____ Sex: M / F
**Email**: _____
Reason for consulting our office:_____
Who may we thank for referring you?_____

## Consent for Chiropractic Care

Being the parent/legal guardian of this child, I hereby authorize this Dr. Greeley, DC CACCP and/or associates to evaluate and treat my son/daughter (name)_____ as they deem necessary. I also acknowledge and agree that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided.
Parent/Guardian's Name(Print) _____
Parent/Guardian's Signature:_____
Date: _____ Witnessed by:_____

## Payment Information

Please read and sign our financial agreement and terms of acceptance. If you have health insurance that may cover chiropractic care, please provide your current insurance card so that we may make a copy and fill out the following for the individual who is responsible for the child's health insurance coverage.
Insured Name:_____ Insured DOB:_____SS#_____
Insurance Co Name:_____ ID#_____

## Heath Profile

***Why is this information important?***

*As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.*

### Addressing the issues that brought you to the office

If your child has no symptoms or complaints, and is here for wellness services please check □;
Others need to briefly describe the chief area of complaint, including the effect it has on the child and any treatment tried to date for this complaint:_____
_____
_____

If he/she is experiencing pain, is it □ Sharp □ Dull □ Comes and Goes □ Travels □ Constant
Since the problem started, is it: □ About the same □ Getting better □ Getting worse
What makes it worse:_____
What makes it better:_____
Does it interfere with : □ School □ Sleep □ Walking □Sitting □Hobbies □Other:_____
Other Doctors seen for this problem:
Chiropractor:_____
Medical Doctor:_____
Other:_____

**Check any of the following Conditions your child has suffered from during the past six months:**

| | | | |
|---|---|---|---|
| □ Ear infections | □ Scoliosis | □ Seizures | □ Chronic Colds |
| □ Headaches | □ Asthma/allergies | □ Digestive problems | □ ADHD |
| □ Recurring Fevers | □ Growing/Back Pains | □ Car Accident | □ Bed Wetting |
| □ Colic | □ Temper Tantrums | □ High fevers | □ Head Injuries |
| □ Repetitive falls | □ Serious illness | □ Epilepsy | □ Meningitis |
| □ Dizziness | □ Diabetes | □ Fainting | □ Sinus Problems |
| □ High Blood Pressure | □ Heart Disease | □ Constipation | □ Diarrhea |
| □ Rheumatic Fever | □ Joint or muscle pain | □ Neck Pain | □ Surgeries |

□ Hypoglycemia (low blood sugar) □ Bladder control problems ( enuresis)
□ Chemical sensitivities □ Environmental allergies
Has the child had prolonged use of medicines or an inhaler □ No □ Yes How long?_____
□ Adverse reactions to any vaccinations (even if mild) Please explain: _____
_____
Other_____

*Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.*

## Pregnancy History (Mother)

Did you experience any of the following during your pregnancy?
*(If the child is adopted answer to the best of your ability)*

| | | |
|---|---|---|
| □ Severe viral infection during 1st trimester | □ Breech position during pregnancy | □ Diabetes |
| □ Accident or Infections | □ Severe Stress | □ Pre-eclampsia |
| □ Alcohol consumption or drug use | □ Radiation Exposure | □ Toxemia |
| □ Hypertension ( High Blood Pressure) | □ Toxoplasmosis | □ Smoking |

Were there any other complications to the pregnancy? □ Yes □ No _____
Was mom on any medications during pregnancy □ Yes □ No _____
Approximately how many ultrasounds were performed?_____

## Labor and Delivery

Where was baby born? □ Home □ Birthing Center □ Hospital □ Other :_____
Was the delivery: □ Vaginal □ Elective C-Section □ Emergency C-section
Was an epidural administered? □ Yes □ No
Where any devices used? □ Forceps □ Suction Cup □ Premature baby (2+ wks)
□ Long/ or difficult labor □ Induced labor □ Rapid delivery □ Breech birth
□ Placenta Previa □ Fetal Distress □ "blue baby" □ Cord around the neck

## Newborn History

□ Required resuscitation/ Oxygen □ Distorted Skull □ Prolonged Jaundice
□ Difficulty Latching/sucking □ Poor sleeper □ Colic
Breastfed □ Yes □ No, How long?_____
Formula Fed □ Yes □ No How long?_____
Introduced to solids at _____Months Cow's milk at _____Months
Any food allergies or intolerances □ Yes □ No List:_____
_____
Birth Weight:_____ Birth Length:_____ APGAR Score:_____
Current Medical Pediatrician_____ Phone #_____

# Developmental History

*According to the National Safety Council approximately 50% of children fall head first from a high place during their 1st year of life (ex. Bed, changing table, stairs, etc.)*

Was this the case with your child? □ Yes □ No
Has your child ever been in a car accident? □ Yes □ No When?_____
Has your child had any childhood illnesses? □ Yes □ No Which?_____
Has your child had any surgeries □ Yes □ No Describe _____
_____
Does your child play any sports □ Yes □ No Which?_____
Weight of School Back Pack? _____lbs
Average # of hours per week playing video games or watching TV?_____
What age did your child crawl?_____ What age did your child walk unassisted? _____

***Does or did your child have any of the following?***

□ Difficulty with crawling (on all fours)
□ Difficulty learning to ride a bike
□ Difficulty learning to read
□ Difficulty using utensils
□ Difficulty tying shoes
□ Poor hand-eye coordination
□ Did not crawl on all fours
□ Appears clumsy
□ Difficulty with writing
□ Difficulty buttoning clothing
□ Difficulty or awkward with walking/running
□ Difficulty sitting still or paying attention

# Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom;

□ Hearing loss or impairment
□ Neurological disorders
□ Obsessive Compulsive Disorder (OCD)
□ ADD/ ADHD
□ Dyslexia
□ Visual impairment
□ Anxiety/ Depression
□ Autism/ Autism Spectrum Disorder
□ Tourette's Syndrome
□ Other _____

Current/Past Medications and Treatment

List any medications that your child is taking:
List names, dosage, frequency
_____
_____

List any special dietary needs that your child has:
_____
_____
_____

List any supplements that your child takes:
_____
_____
_____

List any treatment that your child is currently undergoing with any health professional:
_____
_____

List any special services that your child is currently receiving at school or privately;
_____
_____
_____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:
_____
_____

Comments:_____
_____
_____

*The statements made on this form are accurate to the best of my recollection and I hereby authorize this office and it's Doctors to administer care to my Son / Daughter as they deem necessary. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize payments from my insurance carrier directly to this office with the understanding that all monies will be credited to this account upon receipt. However, I clearly understand and agree that all services rendered to my son /daughter will be immediately due and payable.*

Parent's signature:_____ Date:_____

Austin Wellness Chiropractic Center

# TERMS OF ACCEPTANCE

- When a patient seeks Chiropractic health care and the chiropractor accepts the patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal: To find and correct VERTEBRAL SUBLUXATIONS, therefore allowing the body the potential to heal itself more efficiently. It is important that every patient understand both the objective and the method used to attain that goal. This will prevent any confusion or misunderstandings.

**VERTEBRAL SUBLUXATIONS**: A misalignment or loss of motion of one or more of the 24 vertebrae in the spinal column, which alters the normal nerve system function and interferes with the transmission of mental impulses. This interference results in decreased communication between the brain and the body. This lack of normal communication interferes with the body's innate ability to express its optimum health potential and heal properly

**ADJUSTMENT:** An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

**HEALTH:** A state of optimal physical, mental and social wellbeing; not merely the absence of symptoms, sickness or disease.

- **We do not offer to diagnose or treat any disease or condition other than vertebral subluxations.** However, if during the course of your chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will notify you. I f you would like advice, diagnosis or treatment for those findings, we will refer you to a healthcare provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. In addition, we do not offer advice regarding the 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 used is the specific adjustment, to correct vertebral subluxations.

**Informed Consent for Chiropractic Care**

- Chiropractic Care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.
- Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and in particular your spine health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.
- Any and all questions regarding doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessments I, therefore, accept chiropractic care on this basis.

I, _____ have read and understand the above statements.
(Print Name)

_____ _____
(Signature) (Date)

_____ _____
*Parent or legal guardian if minor* (Date)

_____ _____
Witness Signature (office Staff) (Date)

# PATIENT RECORD OF DISCLOSURES

*Please PRINTand COMPLETE all SECTIONS below*

Patient Name:_____
HomeAddress:_____
Phone:_____ DOB:_____

By my signature below, I hereby authorize Austin Wellness Chiropractic Center ("practice") to disclose my protected health information (PHI) so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's treatment, payment, and health care operations (TPO), (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

With this consent, Austin Wellness Chiropractic Center may call my home or other alternative location and leave a message on voice mail, e-mail, text, or in person in reference to any items that assist the practice in carrying out treatment, such as appointments reminders, insurance issues, and any calls pertaining to my clinical care, including laboratory results.

With this consent, Austin Wellness Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient financial statements. Please check your preferred contact method. (you may check more than one)

☐ **Email/Patient Portal** ☐ **Mail** ☐ **Phone/Text**

With this consent, Austin Wellness Chiropractic Center may speak with the following. List family members, friends, etc. whom you would like to have access to your protected health information to assist the practice in carrying out TPO, such as discussing any open or unpaid balance of my financial account, including visit reason, insurance-related matters, or any other medical issues.

Name:_____, Relationship_____
Name:_____, Relationship_____
Name:_____, Relationship_____

I have the right to request that Austin Wellness Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

*By signing this form, I am consenting to allow Austin Wellness Chiropractic Center to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Austin Wellness Chiropractic Center mya decline to provide treatment to me.*

*I have the right to review the Notice of Privacy Practices prior to signing this consent. Austin Wellness Chiropractic Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained through our office.*

*I have reviewed this office's Notice of Privacy Practices (HIPPA), which explains how my medical information can be used and disclosed. I understand that I am entitled to receive a copy of this document.*

_____
Print Name

_____ _____
Patient's Signature Date

# OFFICE POLICIES & CONTACT PERMISSION

*Please PRINT and COMPLETE ALL SECTIONS Below*

Dear Practice Member:

**OFFICE POLICIES:**

1. **Your compliance** to the doctor's recommended care plan is a key determining factor to the success of your case. Without your complete commitment success is not possible. We are committed to a successful process and outcome for you, therefore we will diligently support the maintenance of your adjustment schedule and outlined care. We understand things come up so we ask that you give at least 24- hour notice of appointment cancellation and we ask that you reschedule that appointment with in a week to insure we keep the rhythm of the adjustments. Too often, appointments are missed but not cancelled, causing valuable appointment space to be lost. To minimize this problem, we are instituting a **$25.00 "No Show Fee"** which you will be billed for, should you fail to cancel your appointment within 24 hours. You may cancel by phone message, text or e-mail. **If you have more than 3 missed/cancelled appointments without rescheduling them we can only interpret this to mean that your commitment to your care has changed, and your care will be suspended.**

2. **We file Insurance as a courtesy**. We are not contracted by any providers therefore we are billing out of network and are subjected to deductibles and co-pays. However, if we do not receive payment from the insurance company within 90 days, it then becomes the patient's responsibility, and the patient will be billed. If you happen to receive a check in your name for services we rendered you will need to reimburse the office within **7 days** of receiving that check and provide Austin Wellness Chiropractic Center with the Explanation of Benefits (EOB) for that date of service.

3. **What to expect on your first visit:** You will have a complete chiropractic consultation and examination. The doctor will review their findings and may choose to administer an adjustment on the same day if warranted. After your first visit you will be scheduled for a second follow up visit to go over your results and you will be given your Doctor's recommended care plan. Should you choose to start care at the second visit your visits will begin and your financial plan will be discussed and first payment will be made.
   **If you are married**, it is the doctor's strongest recommendation that your spouse attend the second report of findings report so that they have the best opportunity to fully understand the doctor's findings and recommendations and have any of their questions answered
4. **Email/text:** In order to provide future appointment confirmations, office appointments, newsletters, educational articles, and/or other information from Austin Wellness Chiropractic Center, we would like permission to use your email and/or your cellular telephone number. I understand that the above information will be kept private and confidential, and **I give permission for Austin Wellness Chiropractic Center to email and/or text me as needed.**
5. Should the opportunity come up to have my child or myself photographed, placed on video, or use of the written word of my success story to be documented through research or social media I do so with the understanding that I will be notified first and will sign a waiver to that extent.

- Email Address:_____Cell Phone:_____
- Printed Patient Name:_____
- Patient Signature:_____☐check here if signing for minor
- Date of Birth: _____

I, _____, have read and understand the policies described above.

Signed :_____ Date:_____