



Balanced Life

CHIROPRACTIC

PEDIATRIC HISTORY FORM

Today's Date: _____

FILE #: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: ____ - ____ - ____ Age: ____ Male Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Birthdate: ____ - ____ - ____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: ____ - ____ - ____

Father's Phone: Home _____ Work _____ Mobile _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: ____ - ____ - ____ Reason for visit: _____

Who is responsible for this bill? _____

Father's Social Security #: ____ - ____ - ____

Mother's Social Security #: ____ - ____ - ____

Father's Driver's License #: _____

Mother's Driver's License #: _____

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. Has this problem occurred before? No Yes If yes, when? _____

3. Any bowel or bladder problems since this problem began? No Yes **If yes**, describe: _____

4. Have you seen any other doctors for this problem? No Yes **If yes**, whom? _____

5. How long ago? ____ Days ____ Weeks ____ Months ____ Years

What were the results of past treatment? _____

6. How is this problem NOW?

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Rapidly Improving Improving Slowly About the Same Gradually Worsening On and Off

7. Please list any medication(s) taken for this problem: _____

8. Has your child ever sustained an injury playing organized sports? No Yes **If yes**, please explain:

9. Has your child ever sustained an injury in an auto accident? No Yes **If yes**, please explain:

BIRTH & CHILDHOOD HISTORY

Any complications during birth or mother's pregnancy?	YES / NO	Details:		
Type of delivery:	C-Section	Vaginal	How long was labor and delivery?	
What did the care provider use to assist in delivery?	Hands	Vacuum	Forceps	Unassisted
Were you vaccinated?	YES / NO	List any reactions/injuries (ex: fever):		
List any over-the-counter or prescription medications frequently used as a child	YES / NO	Details:		
Did your parents worry often about your health?	YES / NO	Due to health issues, did you miss school and other activities?	YES / NO	Details:

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HAS YOUR CHILD EVER SUFFERED FROM - Check all that apply

- | | | | |
|--|--|--|---|
| <input type="radio"/> Headaches | <input type="radio"/> Orthopedic Problems | <input type="radio"/> Digestive Disorders | <input type="radio"/> Behavioral Problems |
| <input type="radio"/> Dizziness | <input type="radio"/> Neck Problems | <input type="radio"/> Poor Appetite | <input type="radio"/> ADD/ADHD |
| <input type="radio"/> Fainting | <input type="radio"/> Arm Problems | <input type="radio"/> Stomach Aches | <input type="radio"/> Ruptures/Hernia |
| <input type="radio"/> Seizures/Convulsions | <input type="radio"/> Leg Problems | <input type="radio"/> Reflux | <input type="radio"/> Muscle Pain |
| <input type="radio"/> Heart Trouble | <input type="radio"/> Joint Problems | <input type="radio"/> Constipation | <input type="radio"/> Growing Pains |
| <input type="radio"/> Chronic Earaches | <input type="radio"/> Backaches | <input type="radio"/> Diarrhea | <input type="radio"/> Asthma |
| <input type="radio"/> Sinus Trouble | <input type="radio"/> Poor Posture | <input type="radio"/> Hypertension | <input type="radio"/> Walking Trouble |
| <input type="radio"/> Scoliosis | <input type="radio"/> Anemia | <input type="radio"/> Colds/Flu | <input type="radio"/> Sleeping Problems |
| <input type="radio"/> Bed Wetting | <input type="radio"/> Colic | <input type="radio"/> Broken Bones | <input type="radio"/> Fall off swing |
| <input type="radio"/> Fall in baby walker | <input type="radio"/> Fall from bed or couch | <input type="radio"/> Fall from crib | <input type="radio"/> Fall down stairs |
| <input type="radio"/> Fall off bicycle | <input type="radio"/> Fall from high chair | <input type="radio"/> Fall off slide | |
| <input type="radio"/> Fall from changing table | <input type="radio"/> Fall off monkey bars | <input type="radio"/> Fall off skateboard/skates | |
| <input type="radio"/> Allergies to _____ | | | |
| <input type="radio"/> Other: _____ | | | |

I understand that I am directly and fully responsible to Balanced Life 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 Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

PATIENT'S NAME: _____ HR#: _____ DATE: _____

ACTIVITIES OF LIFE

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

ACTIVITIES:

EFFECT:

Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewer

PATIENT'S NAME: _____ HR#: _____ DATE: _____

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its worst? _____%

Name: _____ Date: _____

Score: Q1 _____ + Q2 _____ + Q3 _____ + Q4 _____ = _____ / 3x10 = _____ (Low Intensity = <50; High Intensity = >50)

PATIENT'S NAME: _____ HR#: _____ DATE: _____

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This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and 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. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775 ☒ www.hhs.gov/ocr/privacy/hipaa/complaints/

PATIENT'S NAME: _____ HR#: _____ DATE: _____

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...

Please complete the following where indicated and return to our front desk staff.

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

I hereby acknowledge I have read and received a copy of Balanced Life Chiropractic Privacy Practices 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 Practices" 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 the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only

Signed form received by:

Reason acknowledgment not obtained:

Efforts to obtain:

PATIENT'S NAME: _____ FILE #: _____ DATE: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, _____ authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____

Parent's Name: _____

Daytime Phone: _____

Daytime Phone: _____

Evening Phone: _____

Evening Phone: _____

Cell Phone: _____

Cell Phone: _____

Signature of Parent or Legal Guardian

Date

Balanced Life 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 risks are most often very minimal, 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 Balanced Life 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.

Patient Name (print)

_____/_____/_____
Patient or Authorized Person's Signature Date



Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

- 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.

Patient Name (print)

_____/_____/_____
Patient or Authorized Person's Signature Date



Witness Initials