NUZZI CHIROPRACTIC
LIFESTYLE WELLNESS CENTER

Pediatric History (12-17) Date_____

Patient Name _____Date of Birth _____Sex: M F

Name of Parent/Guardians _____

Address _____

City _____ State_____ zip code _____

Home phone number _____ Cell number _____

Email Address _____

Primary Language _____ Race _____ Ethnicity _____

Current Height_____ Current Weight _____

Name of School_____ Grade/level of Education _____

What is the Major complaint or reason for the visit?

_____

What may have **caused or contributed** to this condition or problem?

_____

How long have you been suffering from this condition?

_____

Have you suffered with this prior? If so, how often and what have you done to treat it in the past?

_____

_____

How would you **describe t**he pain? (I.e. burning, sharp, dull, etc.)

_____

What makes the pain or condition **worse**? (I.e. Activity, sitting, standing, driving)_____

When is the pain or condition worse in the morning, mid-day, evening or does it wake you at night?

_____

What makes the **condition better**? (I.e. Rest, ice, moist heat)

_____

Name _____ **Date** _____

How would you **rate** the pain using a pain scale 0-10? (0 being perfect no pain and 10 being severe disabling pain)

_____

What have you done to attempt to resolve the above complaint? (I.e. consult with another doctor, physical therapy, occupational therapy)_____

How would you like to see this condition improve to make the greatest impact on your life or family life?

_____

What are the additional health concerns or conditions you suffer from?

_____

If any please give details about the above concerns.

_____

_____

What medications are you currently taking and what are the medications being used for?

_____

Please list any allergies.

_____

_____

List any minor or major trauma's you may have suffered from birth to current, i.e. and please include falling off changing table, falling down stairs, motor vehicle accidents, birth traumas or difficulties with the birth, sporting injuries or any other.

_____

_____

Was treatment received for any of the above traumas and if so what was done for you?

_____

Do you participate in sports, if so which sports, what is the frequency and intensity of participation?

_____

_____

How would you rate your posture: poor (often sitting with a round back or improperly) fair (sitting up fairly well) or excellent (my child sits correctly at all times and his or her posture is of no concern)

Do you have a disability classification? _____

What is the classification and what services do you or have you received?

_____

Please list some of lifestyle habits you or a member (s) of your family have that maybe having a negative impact on your health, for example does anyone In the house hold smoke, drink beyond social situations,

Name _____ **Date** _____

use illegal substance or any other situation or circumstance that may be prohibiting your physical, chemical or emotional health?

_____

What are the positive lifestyle habits that you or your family have that are having a health benefit? (I.e. Drinking water or healthy beverages, taking supplementation, multivitamin, exercising regularly)

_____

_____

Additional notes or comments given by the Parent or Guardian during the consultation:

_____

_____

Do you experience any pain while:

1.	Bending	Yes	No	Can't
2.	Caring for Children	Yes	No	Can
3.	Carrying	Yes	No	Can
4.	Climbing	Yes	No	Can
5.	Dressing	Yes	No	Can
6.	Driving	Yes	No	Can
7.	Exercising	Yes	No	Can
8.	Gardening	Yes	No	Can
9.	Lifting	Yes	No	Can
10.	Lying down or sleeping (please circle)	Yes	No	Can
11.	Performing daily household chores	Yes	No	Can
12.	Pushing or pulling (please circle)	Yes	No	Can
13.	Rolling over in bed	Yes	No	Can
14.	Running	Yes	No	can
15.	Shoveling	Yes	No	Can
16.	Sitting or sitting to standing (please circle)	Yes	No	Can
17.	Standing	Yes	No	Can
18.	Walking	Yes	No	Can
19.	Watching TV	Yes	No	Can
20.	Working or computer work (please circle)	Yes	No	Can

Treatment Authorizations and Releases

Patient's Name: _____

Parent / Guardian's Name If Signing For Patient: _____

Consent for Treatment/ Payment Agreement

I, the undersigned, hereby authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering physician(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that referrals from my primary care physician, when necessary, are entirely my responsibility and that if one is not obtained I will be expected to pay regardless of my insurance coverage. I understand and agree that if any payments due by me are not made in a timely manner (60 days from initial billing), I will be responsible for late charges, interest of 1 ½% per month, and any applicable collection fees as permitted by law. Furthermore, I understand that any amount authorized to be paid by my insurance will be paid directly to this office and credited to my account. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature: _____ Date / / Witness: _____

Authorization to Release Medical Information

I authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering Physician to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall include any and all information necessary to process my insurance claims and remains valid indefinitely. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature: _____ Date: / / Witness: _____.

Request for Payment of Benefits to Provider of Care

I hereby irrevocably authorize my insurance company / insurance administrator to pay by check made out and mailed directly to: Dr. Lori A. Nuzzi, or Nuzzi Chiropractic Family & Sports Center, the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by the above named Doctor of Chiropractic to be released to any representative of their offices. I have agreed to pay, in a current manner, any balance of said applicable charges I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I authorize the office to act in my behalf and report any suspected violations of proper claims practices by my insurance company to the proper regulatory authorities.

Patient's Signature: _____ Date: / / Witness: _____

Consent for Treatment of Minor

I hereby authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering physician(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as she deems necessary to my: son/ daughter ,Name:_____

Parent/Guardian's Signature: _____ Date: / / Witness: _____

HIPAA Compliance

The office of Dr. Lori A. Nuzzi and its employees may use my health and personal information in any way necessary to obtain payment for services. This includes but is not limited to: filing claims, obtaining pre-authorizations, referrals, and billing outstanding balances. This information may also be shared with my other treating physicians or technicians as necessary. While every effort will be made to keep this information confidential, I understand that some information such as my name or a portion of my name may be used in the presence of others.

Patient's Signature: _____ Date: / / Witness: _____