

Pediatric Health History Form

Child's Name: _____ Date: _____ Patient Number: _____

Parent Names: _____ Sibling's Names & Ages: _____

Child's Age: _____ Birth date: _____ (dd/mm/yyyy) Sex: M F

Address: _____

Home Phone: _____ Other Number: _____

Family doctor's name: _____ Address: _____

Who may we thank for referring you? _____

Has your child ever received chiropractic care? Yes No

If yes, who is your child's previous Doctor of Chiropractic?: _____

The date of last visit: _____

The reason for the last visit: _____

Other professionals seen for this condition: _____

Results with that treatment? _____

Recent tests done (list date beside): Bloodwork _____ Urine _____ X-Rays _____

Other: explain _____

Please tick the purpose for your child's visit:

- crisis management early detection of problems prevention wellness
 maximizing normal growth and development other: _____

Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: _____ Date: _____

Signature: _____ Witness: _____

Doctor of Chiropractic:

Address: _____

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Present Health Concerns

Major _____

Minor _____

When did this problem begin? _____

Is this problem: occasional frequent constant intermittent

Does problem radiate? Yes No If Yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No

If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No Daily routine? Yes No

Is this becoming worse? Yes No

Often seemingly unrelated symptoms can manifest as other health concerns..

Please tick if your child has had any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chest pressure | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> breast pain | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> irritability | <input type="checkbox"/> frequent colds | <input type="checkbox"/> dental problems |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> fevers |
| <input type="checkbox"/> depression | <input type="checkbox"/> sore throats | <input type="checkbox"/> heart palpitations |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> numbness in feet |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> asthma | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> fainting | <input type="checkbox"/> cold sweats | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears buzzing | <input type="checkbox"/> bronchitis | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> poor coordination | <input type="checkbox"/> pneumonia | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> allergies | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> constipation | <input type="checkbox"/> radiating pain |
| <input type="checkbox"/> light sensitivity | <input type="checkbox"/> diarrhea | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> face flushed | <input type="checkbox"/> urinary problems | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> reduced mobility | <input type="checkbox"/> bloating/gas | <input type="checkbox"/> stiffness |

Other: _____

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Birth History

What was the child's gestational age at birth? _____ weeks.

Birth weight _____ lbs _____ oz Birth length _____ inches

Was your child's birth: at home in a birthing center hospital other

Was the birth considered: medical midwife Duration of birth: _____ hours

Was child born: cephalic (head first) breech (feet first)

Were there any complications? Yes No If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labour: spontaneous induced

Were medications or epidurals given to the mother during birth? Yes No

APGAR score: at Birth _____/10 After 5 minutes _____/10

Is there anything else we need to know about the birth Yes No

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain _____

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____

Does your child sleep: front back side

Do you consider the child's sleeping pattern normal? Yes No How many hours per day? _____

If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) Yes No

If yes, please explain _____

Any evidence of birth trauma to the infant?

- bruising
- odd shaped head
- stuck in birth canal
- fast or excessively long birth
- respiratory depression
- cord around neck

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Any falls from couches, beds, change tables, etc? Yes No

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain _____

Any hospitalizations or surgeries? Yes No

If yes, please explain _____

Any sports played? _____

Is a school backpack used? Yes No

Is it heavy or light?

Chemical Stressors

Was this child breast-fed? Yes No

If yes, how long: _____

Formula introduced at what age: _____

Which formula? _____

Introduction of cow's milk at what age: _____

Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No

Type: _____

Is your child on or have taken any medications? _____

During the mother's pregnancy:

Did the mother smoke? Yes No

How much? _____

Drink alcohol? Yes No

How much? _____

Any illnesses during the pregnancy? Yes No

If yes, describe: _____

Any supplements taken during pregnancy? Yes No

If yes, describe: _____

Any drugs taken during pregnancy? Yes No

Any ultrasounds? Yes No

How many: _____

Reasons for being done: _____

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? Yes No

If yes, please explain _____

Any pets at home? Yes No

Any smokers in the home? Yes No

Any antibiotics given? Yes No

If yes, reason: _____

Is the diet organic? Yes No

Do you use 'green products' in your home for cleaning? Yes No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? Never On

weekends *A few times per week* *Daily* *Nearly each meal* *On special occasions*

Are you aware of the impact of nutrition on children's behavior? Yes No

Would you like information on nutrition for your child? Yes No

Psychosocial Stressors

Any difficulties with lactation? Yes No

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Any problems with bonding? Yes No _____

Any behavioral problems? Yes No _____

Any inattention? Yes No _____

Any hyperactivity or restlessness? Yes No _____

Any compulsiveness? Yes No _____

Any difficulties at daycare or school? Yes No _____

Any challenges with learning deficiencies? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Any prolonged temper tantrums or separation anxiety? Yes No _____

Is the child in day care Yes No _____

Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work Yes No _____

Is the child home schooled? Yes No _____ by Whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? Yes No How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Buckeye Chiropractic/Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, and Rachel Frinak CNP** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been or will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.
(SEAL)

X _____

(patient signature)

X _____ (SEAL)
(signature of Guardian if applicable)

X _____
(please print patient name)

BUCKEYE CHIROPRACTIC & WELLNESS/SYNERGY MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Female Patients Only:

_____ I am pregnant

_____ I am NOT pregnant

Buckeye Chiropractic & Wellness/Synergy Medical

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Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with the quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purpose: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature: _____ Date: _____

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my
primary care physician of my condition, treatment
and expected/actual response to care at this office.

Patient/Guardian Signature: _____

Name (Please Print): _____

Primary Care Physician: _____

Physician's Address/Phone: _____



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