PEDIATRIC HISTORY FORM

Welcome to Olar Family Chiropractic!

FILE NUMBER:_____

Name:_____ Date:_____
Address:_____City:_____ State:_____ ZIP:_____
E-mail:_____ Date of Birth: _____/_____/_____
Cell #: _____ Home #:_____ Work #:_____
Occupation:_____ Employers Name:_____
Marital Status: S M D W Spouse Name:_____ # of Children:_____

Insurance:

Primary Insurance Name:_____
Policy #:_____ Group #:_____
Policy Holder Name:_____ DOB:___/___/___
Relationship:_____

Secondary Insurance Name:_____
Policy #:_____ Group #:_____
Policy Holder Name:_____ DOB:___/___/___
Relationship:_____

REASON FOR VISIT? :_____

When did it start?:_____ Has this occurred before? ☐YES ☐NO
Sensations are: ☐ SHARP ☐DULL ☐ THROBBING ☐ NUMBNESS ☐ PAIN TRAVELS
Has this condition: ☐ GOTTEN BETTER ☐ STAYED CONSTANT ☐COMES AND GOES
Does this condition interfere with: ☐SLEEP ☐DAILY ROUTINE ☐OTHER ACTIVITIES:_____

CHILD'S HEALTH HISTORY:

INSTRUCTIONS: CHECK ANY OF THE FOLLOWING CONDITIONS OR DISEASES YOUR CHILD HAS NOW OR HAS SUFFERED IN THE PAST. WHILE THEY MAY SEEM UNRELATED TO THE PURPOSE OF THE APPOINTMENT, THEY CAN AFFECT THE OVERALL DIAGNOSIS, CARE PLAN and THE POSSIBILITY OF BEING ACCEPTED FOR CARE.

☐ EAR PROBLEMS	☐SLEEPING DISORDERS	☐ SEIZURES	☐ FREQUENT COLDS	☐HEADACHES
☐ ASTHMA/ALLERGIES	☐ DIGESTIVE PROBLEMS	☐ ATTENTION PROBLEMS	☐ RECURRING FEVERS	☐GROWING/BACK PAINS
☐ COLIC	☐ BED WETTING	☐ TUBES IN THE EARS	☐ TEMPER TANTRUMS	☐OTHER_____

According to the National Saftey Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed changing table, down stairs, etc.).
Was this the case with your child ? ☐YES ☐NO

Has your child been involved in any high impact or contact type sports? ☐ YES ☐NO, List: _____

Has your child ever been involved in a Car Accident ? ☐YES ☐NO , List: _____

Has Your Child Been Seen on an Emergency Basis ? ☐ YES ☐NO , List: _____

Other traumas not described above ? ☐Yes ☐No , List: _____

Prior Surgery?: ☐ YES ☐ NO , List: _____

Is your child accident prone? ☐YES ☐NO Please explain: _____

Is your child currently taking medications? ☐YES ☐NO Please explain:_____

Does your child have difficulty interacting with others? ☐ YES ☐ NO Please explain:_____

Ever noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? ☐ YES ☐ NO
Please explain:_____
_____

PRENATAL HISTORY:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? ☐ Yes ☐ No , List:_____

Ultrasounds during pregnancy? ☐ Yes ☐ No , Number:_____

Medications during pregnancy/delivery? ☐ Yes ☐ No , List:_____

Cigarette / Alcohol use during Pregnancy: ☐ Yes ☐ No

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Ceasarian ☐ Labor was Doctor assisted
☐ Doctor pulled or twisted baby ☐ Premature delivery

Complication During Delivery: ☐ Yes ☐ No , List:_____

Genetic Disorders or Disabilities: ☐ Yes ☐ No , List:_____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

FEEDING HISTORY:

Breast Fed: ☐ Yes ☐ No , How Long:_____

Formula Fed: ☐ Yes ☐ No , How Long:_____

Did you experience feeding problems ☐ Yes ☐ No

Introduced to Solids at:_____ Months & Cows' Milk at _____Months

Food / Juice Allergies or Intolerances: ☐ Yes ☐ No , List:_____

DEVELOPMENTAL HISTORY:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____Respond to sound
_____Respond to Visual Stimuli
_____Hold Head Up
_____Sit Up
_____Cross Crawl
_____Stand Alone
_____Walk Alone

What changes in your child's health or behavior would you like accomplished?_____
_____

VACCINATIONS

Have you chosen to vaccinate your child? ☐ YES ☐ NO

If Yes, Check all that your child has received: ☐ DPT ☐ MMR ☐ CHICKEN POX ☐ HEPATITIS ☐ OTHER

Describe any and all reactions to vaccine(s): _____

Survey Questions:

Who may we thank for referring you to our clinic? _____

You seen or heard of our office because of: ☐ NEWSPAPER ☐ PHONE BOOK ☐ COMMUNITY EVENT ☐ INTERNET ☐ BENCH BILLBOARD ☐ TV

Was it easy to locate the clinic?: ☐ YES ☐ NO

Have you been adjusted by a chiropractor before? ☐ YES ☐ NO

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physicians's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	**RELATIONSHIP TO PATIENT:**
SIGNATURE:	**DATE:**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

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 very 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.

I authorize the release of any chiropractic or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I also authorize direct payment of chiropractic benefits to the chiropractor of services.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	**DATE:**

AUTHORIZATION FOR CARE OF MINOR

I, _____ being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child/children to receive chiropractic care.