JOSHUA SPINE + HEALTH CENTER

CHIROPRACTIC • MASSAGE • WELLNESS

Confidential Patient Information

PEDIATRIC

Date: _____

About Your Child

Name_____
First Last

Who can we thank for the referral?_____

Address _____ City ___-_____ State _____ Zip _____

Guardian Telephone Cell [____]_____ Home [____]_____ Work [____]_____
Is it ok to contact you at work? Yes☐ No☐

Guardian Email _____
Your email will NOT be shared with any 3rd party, and is used for general office communication.

Child's Age _____ Birth Date _____ Sex M☐ F☐ Height _____ Weight _____

Grade: _____ School: _____Activities _____

Family Doctor/Pediatrician _____ Clinic_____ Phone _____

Previous Chiropractic care? Yes☐ No☐ If Yes, where and when? _____

Your Child's Family

Parents/Guardians' Names _____

Cell Phone(s) [_____]_____[_____]_____

Occupation(s): _____ Employer(s) _____

Names and Ages of Siblings_____

Are child's siblings or parents currently under Chiropractic care? Yes☐ No☐ Name of Doctor _____

Your Child's Condition

Purpose of Appointment/Complaint_____

When did it start? _____ Has it happened before? Yes☐ No☐ When? _____

How did it happen? _____

The pain is ☐ constant ☐ comes and goes ☐getting worse Does the pain travel? Where? _____

The pain interferes with ☐school ☐sleep ☐exercise/play ☐daily activities ☐other _____

The pain is aggravated by: ☐moving ☐lifting ☐bending ☐sitting ☐walking ☐lying down ☐other _____

The pain is relieved by: ☐ice ☐heat ☐rest ☐stretching ☐medication_____ ☐other_____

What other professionals have you seen for this condition? _____ Results? _____

Health History

Check any of the symptoms your child has suffered from/been diagnosed with during the past six months:

☐Ear infections	☐Scoliosis	☐ADHD/Hyperactivity	☐Headaches
☐Asthma	☐Bed Wetting	☐Abnormal weigh loss/gain	☐Recurring Fevers
☐Allergies	☐Digestive Problems	☐Chronic colds/sore throat	☐Growing pains
☐Colic	☐Temper Tantrums	☐Seizures	☐Serious fall
☐Headaches	☐Neck Pain	☐Back pain	

☐Other. Please explain _____

- OVER -

Childhood Disease	**Yes**	**No**	**Age**
Chicken Pox	☐	☐	_____
Rubeola (Measles)	☐	☐	_____
Rubella (German Measles)	☐	☐	_____
Whooping Cough	☐	☐	_____
Mumps	☐	☐	_____
Other_____	☐	☐	_____

Vaccination history:

☐ My Child's vaccinations are up to date

☐ My child has not received any vaccinations

☐ I don't know if my child was vaccinated

☐ My child had an adverse reaction to the following vaccine:

_____

Number of doses of antibiotics your child has taken:

1) In past six months_____ 2) Total in his/her life _____

List all other medications (prescription and over-the-counter) taken:

1) Currently: _____ 2) In past year: _____

Feeding History:

Breastfed: Yes☐ No☐ If Yes, how long? _____ Formula: Yes☐ No☐ If Yes, how long? _____

Introduced solids at _____ months. What kind? _____ Cow's Milk at _____ months

Food/drink intolerance? _____

Prenatal History:

Name of Obstetrician/Midwife/Doula: _____

Complications during pregnancy? Yes☐ No☐ If Yes, please explain: _____

Medications during pregnancy? Yes☐ No☐ If Yes, please list them: _____

Cigarette/Alcohol use during pregnancy? Yes☐ No☐ Any smokers in the home? Yes☐ No☐

Was the baby carried Full term? Yes☐ No☐ If No, please explain:_____

Location of Birth: ☐Hospital ☐Home ☐Other: _____

Birth Interventions: ☐C-Section. Planned or Emergency?_____ ☐Forceps ☐Vacuum extraction

☐Epidural ☐Induction Complications during delivery? Yes☐ No☐ If Yes, please explain:_____

Genetic Disorders or Disabilities? Yes☐ No☐ If Yes, please explain:_____

Birth Weight: _____ Birth Length _____

Developmental History:

At what age was your child able to: Sit _____ Crawl _____ Stand alone _____ Walk _____

Has you child ever fallen from a high place during the first year of life (changing table, stairs, stool, etc.)? Yes☐ No☐

Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, etc.)? Yes☐ No☐

Has your child ever:	Yes	No	Briefly explain

Broken bones? ☐ ☐ _____

Been hospitalized? ☐ ☐ _____

Been in a car accident? ☐ ☐ _____

Had Sprains/Strains? ☐ ☐ _____

Been struck unconscious? ☐ ☐ _____

Had Surgery? ☐ ☐ _____

(For girls only) Has your daughter had a menstrual cycle yet? Yes☐ No☐ If Yes, age of her first cycle: _____

Lifestyle

Please list any Vitamins and/or Supplements that your child is taking _____

Please list recent Emotional stressors (divorce, death, loss of a pet, school change, etc.) _____

Does your child ☐drink soft drinks? ☐eat pre- packaged meals/snacks? ☐drink more than 2 glasses of milk/day?

☐Eat candy/cookies? ☐eat fast food? ☐eat boxed cereals

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Insurance Information

Insurance Co _____ Policy # _____ Group # _____

Subscriber's Name _____ Birth Date _____ Relation to patient _____

Additional/Secondary Insurance Co _____ Policy # _____ Group # _____

Subscriber's Name _____ Birth Date _____Relation to patient _____

Please give your insurance card to the front desk so they can verify your coverage.

Auto Injury? Yes☐ No☐ If Yes, please ask the front desk for *Automobile Accident Form*

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures for my child. This includes examination tests, diagnostic x-rays and physical therapy techniques, which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to my child, while employed by , working for , associated with, or serving as backup for the doctor of Joshua Health Center. I understand that X-rays will remain property of this office, being on file where they may be seen at any time while a patient of this office.

I have had an opportunity to discuss with the doctor and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my child's best interest to undergo Chiropractic treatment recommended. I have also been made aware of the risks associated with refusing treatment. I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment for my child. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian Signature _____ Date _____

Assignment of Benefits

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Joshua Spine and Health Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Joshua Spine and Health Center will be credited to my account on receipt. 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.

Also, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Authorization & Release

- ✓ I hereby authorize Dr. Joseph Thomas, D.C. to 1) release any information necessary to insurance carriers regarding my illness and treatments 2) to process insurance claims generated in the course of examination or treatment and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.
- ✓ I have requested medical/chiropractic services from Dr. Joseph Thomas, D.C. on behalf of myself and/or my dependants, and understand that by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized.
- ✓ I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I also understand that if I suspend or terminate my care or treatment, any fees for professional services, which are rendered to me, will be immediately due and payable, unless agreed otherwise. Should my account become delinquent, I will be responsible for any interest (to accrue at 9% annually, commencing 30 days after the initial bill for services issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. A photocopy of this assignment is to be considered as valid as the original.

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition(s). To remove the vertebral subluxations, a specific process us used which is called a chiropractic adjustment. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advice you. Regardless of what the disease is called, we do not offer to treat it.

When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Please feel free to ask for additional information.

Signature: _____ Date: _____

Printed Name of Patient or Legal Representative _____

Joshua Spine and Health Center, Dr. Joseph J. Thomas, D.C

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy and/or have been given the opportunity to review this office's Notice of Privacy Practices.
As required by the Privacy Regulations, I am aware that this practice reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ○ I wish to file a "Request for Restriction" of my Protected Health information.
- ○ I wish to fil a "Request for Alternative Communications" of my Protected Information.
- ○ I wish to object to the following in the "Notice of Privacy Practices":

_____

_____

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Printed Name:_____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

_____

_____