

PEDIATRIC HISTORY FORM

In order to provide you the best possible care, please complete this form.
All information is strictly CONFIDENTIAL.

Patient Data

First Name _____ Last Name _____ Date _____

Mailing Address

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____ (Work) _____

Age _____ Birth Date _____ Height _____ Weight _____ Social Security # _____

Name of Parents / Guardians: _____

Emergency Contact & Phone: _____

Referred By _____ Have you visited our website? No Yes

Current Complaints

Purpose For Contacting Us: _____

Other Doctors Seen for this condition? No Yes If yes, when? _____

Doctors' Names and Prior Treatments: _____

Other Health Problems: _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

Ear Infections Asthma / Allergies Colic Scoliosis Digestive Problems

Seizures Car Accident ADHD Chronic Colds Recurring Fevers

Temper Tantrums Headaches Growing / Back Pains Other _____

Payment Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? No Yes Name of company _____

Signatures

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent's or guardian's signature _____ Date _____

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.) _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There? No Yes

Number of Doses of Antibiotics Your Child has Taken:

During Past 6 Months: _____, Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During Past 6 Months: _____, Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician / Midwife: _____

Complications During Pregnancy? No Yes List: _____

Ultrasounds During Pregnancy? No Yes Number: _____

Medications During Pregnancy / Delivery? No Yes List: _____

Cigarette / Alcohol Use During Pregnancy? No Yes

Location of Birth: _____ Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarian Section, Emergency or Planned? _____

Complications During Delivery? No Yes List: _____

Genetic Disorders or Disabilities? No Yes List: _____

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

Feeding History

Breast Fed: No Yes How Long: _____ Formula Fed: No Yes How Long: _____

Formula Fed: No Yes How Long: _____ Type: _____

Introduced to Solids at: _____ months, Cows' Milk at: _____ months

Food / Juice Allergies or Intolerances: No Yes 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 _____ Cross Crawl _____ Respond to Visual Stimuli
_____ Stand Alone _____ Hold Head Up _____ Walk Alone _____ Sit Up

According to the National Safety 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 of your child? No Yes

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? No Yes

Has your child ever been involved in a car accident? No Yes List: _____

Has your child been seen on an emergency basis? No Yes List: _____

Other traumas not described above? No Yes List: _____

Prior Surgery: No Yes List: _____

Menarche: No Yes List: _____

Childhood Diseases

Chicken Pox: No Yes Age: _____ Mumps: No Yes Age: _____

Rubella: No Yes Age: _____ Whooping Cough: No Yes Age: _____

Rubeola: No Yes Age: _____ Other: No Yes Age: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Appendix B

Acknowledgement of Privacy Notice

As of April 14, 2003, our office is implementing the requirements of the Health Insurance Portability, and Accountability Act (HIPAA), which was passed by the federal legislature.

Your signature is necessary so that we may continue to treat you and submit your information for reimbursement.

Please review the 'Privacy Notice' and indicate that you have reviewed this document by signing below.

“My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider’s Notice Of Privacy Practice.

Print Name

Date

Signature

Ellison Family Chiropractic Terms of Acceptance

Chiropractic:

Chiropractic seeks to restore health through natural means without the use of medicine or surgery. This gives the body the maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic depends on the environment, underlying irritants, physical and spinal problems.

Analysis:

Ellison Family Chiropractic conducts a thorough chiropractic evaluation and utilizes the most recent research evidence and technology to develop a solution for each patient.

Diagnosis:

Dr. Ellison will when necessary refer you to other physicians for consultation and/or additional work up. While Dr. Ellison is an expert in spinal subluxations (misalignments) and misalignments throughout your body, each patient should secure on their own other opinions if the patient has additional concerns about their health.

Informed Consent:

Ellison Family Chiropractic utilizes Activator Methods Chiropractic Technique to adjust patients' spinal subluxations and other misalignments throughout the body. Ellison Family Chiropractic adjusts patients in an open setting to minimize patient wait time, to keep staff involved in patient care and to allow for easier discussion of chiropractic tenets. If the patient is uncomfortable with this style of adjusting please inform the front desk upon arriving and you will be provided with a private room. If you have a question for Dr. Ellison and you would like more privacy, let the doctor or staff know and time will be available to discuss your question.

Results:

The purpose of chiropractic is to promote health through the reduction of subluxations or misalignments using Activator Methods Chiropractic Technique. Since there are so many different variables, it is difficult to predict outcomes. Sometimes response is phenomenal. In most cases response is gradual but satisfactory. And occasionally response is less than expected. Two or more similar conditions often respond differently to chiropractic adjustments.

To The Patient:

Please discuss any questions or concerns with Dr. Ellison or a staff member before signing this policy.

I have read and understand the foregoing.

Signature

Date

Informed Consent For Chiropractic Care

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.

Prior to receiving chiropractic care at Ellison Family Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Relationship to patient

Parent or legal Guardian Signature

Date

Witness Signature (office staff)

Date

ELLISON FAMILY CHIROPRACTIC
1560 N. CRESTMONT DR. STE. G
MERIDIAN, ID 83642
(208) 884-8848

DATE _____

PATIENT _____ DOB _____

EMPLOYER _____

ID#/SS# _____ GROUP _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to Ellison Family Chiropractic, or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the address above for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of policy holder

Signature of claimant, if other than policy holder

Witness