

**CHILDREN'S CONFIDENTIAL PATIENT CASE HISTORY**

Please complete this questionnaire fully. Your answers will help to determine how chiropractic care can help your child.

**PERSONAL INFORMATION:**

Child's First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
What they prefer to be called \_\_\_\_\_  
SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Siblings Y N  
Names/Ages \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
What you prefer to be called \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Email address \_\_\_\_\_ Cell phone \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Status: \_\_\_single \_\_\_married \_\_\_separated \_\_\_divorced \_\_\_widower  
Spouse's Name \_\_\_\_\_

Please initial here if we may add your email address to our mailing list for our Health & Wellness, monthly e-newsletter and occasional correspondence from this office with important updates/notices Yes, Please! \_\_\_\_\_

*The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.*

*From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.*

*The following form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.*

## HEALTH INFORMATION

Please specifically describe your reason for today's visit: \_\_\_\_\_

How did this happen: \_\_\_\_\_

When did this happen: \_\_\_\_\_

Is the pain getting worse: \_\_\_\_\_ yes \_\_\_ no \_\_\_ constant

Has your child had this or similar conditions in the past: \_\_\_yes no

Please explain if yes: \_\_\_\_\_

How frequent is this problem or pain becoming: \_\_\_\_\_

Has a medical doctor treated your child for this: \_\_\_\_\_yes no

If so, whom and when: \_\_\_\_\_

Does this condition interfere with your child's \_\_\_\_\_ Sleep \_\_\_\_\_ School \_\_\_\_\_ Play

Other (explain) \_\_\_\_\_

Is your child currently under the care of a Medical Doctor for any condition \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, for what condition(s) \_\_\_\_\_

Please list any medications that your child is currently taking:

Does your child take any supplements: \_\_\_\_\_yes \_\_\_\_\_no What? \_\_\_\_\_

How much water does your child drink per day: \_\_\_\_\_oz \_\_\_\_\_# of sippy cups

For Menstruating Female Patients. Is there a chance your child is pregnant? Yes No

1. Has your child been checked by a Doctor of Chiropractic? \_\_\_\_\_ Who? \_\_\_\_\_

Were x-rays taken? \_\_\_\_\_.

Who is your regular pediatrician? Name & Phone \_\_\_\_\_

2. Did you have ultrasound during this pregnancy? \_\_\_\_\_ Frequency \_\_\_\_\_

• Place of birth: Home/ Birthing Center/ Hospital .

• Provider: Midwife/ OB-Gyn/ Other \_\_\_\_\_

• Type of Birth: Vaginal / C-section. Was anesthesia used? \_\_\_\_\_ Spinal Epidural  
Other \_\_\_\_\_

• Was labor induced? \_\_\_\_\_ If yes, why? \_\_\_\_\_

• What position did you deliver in: Squatting/ On Back

• Birth Trauma: Doctor assisted/ Twisting, Pulling/ Vacuum Extraction/ Forceps

• Newborn trauma ( medical procedures and tests) \_\_\_\_\_

3. Did you breast-feed your child? \_\_\_\_yes \_\_\_\_ no. How long? \_\_\_\_\_

Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

4. According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child? \_\_\_\_  
Please Describe:

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Any fractures or dislocations? \_\_\_\_\_

5. Which sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Other \_\_\_\_\_.

6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? \_\_yes\_\_ no. Is it in front of a computer or TV? \_\_\_\_\_

7. How would you rate your child's diet?                      Poor                      Fair                      Good  
Excellent                      Does your child consume artificial sweeteners? \_\_\_\_\_  
Flouridated water? \_\_\_\_\_

8. Circle any of the following conditions your child has suffered from :

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies (please list), \_\_\_\_\_

Asthma, Headaches, Poor Digestion, Bloating Abdomen, Constipation/Pain or other Bowel Complaints, Thickly Coated or Patchy White Tongue, Red Ring Around Anal Area, Itchy Genital Area, A Chronic Hair or Foot Odor, Muscle Aches or Weakness, "Spacey" or "Zoned Out" look in eyes, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Eczema, Headaches, Unexplained Aches or Pains Y or N If Yes, where? \_\_\_\_\_ Other Medical Diagnoses or anything else you are concerned about

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9. How often has your child been treated with drugs/antibiotics ? \_\_\_\_\_

Were you informed of their adverse reactions ? \_\_\_\_yes\_\_\_\_ no

If it was an antibiotic, was your child cultured for its use? \_\_\_\_\_

Any surgeries? \_\_\_\_\_

10. The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child? Did your child experience any behavioral , emotional or physical changes within 3 months after any shots? \_\_\_\_\_

Describe \_\_\_\_\_

Was it reported by you or your doctor? \_\_\_\_\_

***Today, we are becoming more aware, how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.***

***Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.***

***Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.***

#### **AUTHORIZATION FOR CARE OF A MINOR**

I hereby Authorize Dr(s). \_\_\_\_\_ to administer care as deemed necessary to my son/daughter.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witnessed \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE POLICY:**

**Are you the person ultimately responsible for this account?**

\_\_\_\_\_ **Yes** \_\_\_\_\_ **No** **If no, who is** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone number** \_\_\_\_\_

**If you are filing this claim with your insurance, do you have your insurance card with you today?** \_\_\_\_\_ **Yes** **No**

**If no, complete the following:**

**Company name:** \_\_\_\_\_

**Insured name:** \_\_\_\_\_

**Insured SS#** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Group #** \_\_\_\_\_ **Employer** \_\_\_\_\_

**FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS**

**We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If all charges are not paid when due, the undersigned agrees to pay costs of collections. Including 33 1/3% attorney's fees or other collection agency fees, PLUS INTEREST AT THE RATE CURRENTLY APPLICABLE BY VIRGINIA STATUTE TO JUDGEMENTS. It is agreed that any legal action for collections of monies due may be properly instituted in the courts of Virginia Beach, VA., and Virginia law shall apply.**

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**Signature**

**Date**

## FINANCIAL AGREEMENT

**Dear Patient:**

**Welcome! You have taken the first step on the path to optimum health. We take pride in delivering the finest in chiropractic care. The following payment options are available to help you handle your financial obligation.**

**We wish to make it very clear that your health is the sole responsibility of you the patient or your guardian.**

**I have elected to use the following payment plan to finance my care:**

- \_\_\_\_\_ **1. CASH/CHECK/CREDIT CARD – Payment is due at the time of service, unless other payment arrangements have been made.**
  
- \_\_\_\_\_ **2. MEDICARE – I understand this office will complete all necessary Medicare forms on my behalf. However, I am responsible for any difference in payment that Medicare does not cover.**
  
- \_\_\_\_\_ **3. PERSONAL INJURY – Although my insurance or lawsuit may eventually pay for services rendered, I will pay this office \$50.00 toward my initial visit, and \$50.00 per week thereafter, until my balance is paid in full, whether active or inactive as a patient.**
  
- \_\_\_\_\_ **4. INSURANCE POLICY COVERAGE – although I am totally responsible for charges I may incur in this office, I will initially pay for my yearly deductible and the copayment agreed upon at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full.**

**Please note: We will refund any overpayment made to this office.**

**PATIENT'S SIGNATURE \_\_\_\_\_**

**WITNESS \_\_\_\_\_ DATE \_\_\_\_\_**

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at our office we may use or disclose personal and health related information about you in the following ways:

- \* Your personal health information, including of your clinical records, may be disclosed to another health provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
  - \* Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
  - \* Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- \* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
  - \* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
  - \* If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- \* If we are providing health care services to you based on the orders of another health care provider.
- \* If we provide health care services to you in an emergency.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information

This notice is effective as of \_\_\_\_\_. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Laura Jennejohn

If you would like further information about our privacy policies and practices please contact:  
Laura Jennejohn

\_\_\_\_\_  
Name (Printed please)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party

\_\_\_\_\_  
Personal Representative (Printed)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient.

**Patient Authorization regarding chiropractic care being provided in an “open adjusting” environment**

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is know as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with out office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on you care from our office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.