LIFE IS GOOD CHIROPRACTIC
PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS **VRC#:**_____

Today's Date _____/_____/_____

Childs Name_____

Date of Birth _____/_____/_____ Age: _____ ☐ Male ☐ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address _____

City _____State _____Zip _____Phone (Home) _____

Mother's Name: _____DOB____/____/_____Mother's Mobile _____

Father's Name: _____DOB ____/____/_____Father's Mobile _____

Pediatrician/Family MD _____City/State _____

Last Visit: ____/____/___Reason for visit:_____

Who is responsible for this bill? _____

☐ Father ☐ Mother ☐ Other *(please explain)*: _____

Who may we thank for referring you? _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Health Concern

Please explain: _____

If your child is experiencing ***Pain/Discomfort please identify where and for how long***

_____

_____

1. **When did the** Problem first begin? Date ___/___/___ _Unknown _Gradual _Sudden
2. **Ever had** this problem **before**? ____No ___Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began? If yes, describe:

_____

4. Have you seen **other doctors** for this problem? _____No ___Yes If yes, who?

_____

5. How long ago? _____Days _____Weeks _____Months _____Years

6. What were the results of past treatment _____

7. How is this problem **NOW**?: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same
☐ On & Off ☐ Gradually Worsening

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ____No ___Yes If yes; please explain:
_____

_____

_____

10. Has your child ever sustained an injury in an auto accident? ____No ___Yes If yes; please explain:
_____

_____

_____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH BIRTH
(Please check any that apply)

During Pregnancy Explain:

◊ Drugs/medicine _____
◊ Tobacco/alcohol _____
◊ Illnesses _____

During Labor and Delivery Explain:

◊ Labor chemically induced _____
◊ Labor doctor assisted _____
◊ C-section delivery _____
◊ Forceps/vacuum extraction _____
◊ Doctor pull or twist baby _____
◊ Premature delivery _____

Since Pregnancy Explain:

◊ Nursed how long _____
◊ Baby jaundiced _____
◊ Feeding problems _____
◊ Sleeping problems _____
◊ Colic _____

Vaccinations

◊ None
◊ Only selected vaccines _____
◊ Delayed schedule _____
◊ Regular schedule _____
◊ Any vaccine reactions _____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to _____

☐ Other: _____

I understand that I am directly and fully responsible to Life is Good Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to select and authorize this care should change in any way, I will immediately notify this office.

_____ _____
Parent or Legal Guardian's Signature Date

_____ _____
Doctor's Signature Date

Life Is Good Chiropractic

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, palpation, and radiological examination (x-rays).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE LIFE IS GOOD CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ **_____**
Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

Remarks:

VRC# _____
(Staff use only)

Medical Information Release Form
(HIPAA Release Form)

Name:_____ Date of Birth:_____
Emergency Contact Information:
Name: _____
Relationship:_____
Phone Number:_____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone

This Release of information will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number:_____

Do we have your permission to send a text message ? Yes No

Do you prefer ? [ ] A phone call [ ] A text message

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (day)_____between (time)_____

Signed:_____Date:_____

Witness: _____ Date: _____

LIFE IS GOOD CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Bryn Gillow at (570) 992-2929. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

VRC _____
(Staff Use Only)

Patient initials: _____ -retaining page 1 of 2

LIFE IS GOOD CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Life is Good Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Print Patient's Name:_____

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____