Date_____ VRC# _____
(staff use only)

Life is Good Chiropractic Pediatric History Form

Patient Demographics

Patient Name_____ Birth Date:_____ Age:_____ Sex: M or F

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

Address:_____City: _____ State:_____ Zip:_____

Mothers Name:_____ D.O.B:_____ Mothers Mobile:_____

Fathers Name:_____ D.O.B:_____Fathers Mobile:_____

Pediatrician/Family MD _____City/State _____

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

Health Information

Purpose of the 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
_____

_____

When did the Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden

Ever had this problem before? ___ No ___Yes If yes, when? _____

Any bowel or bladder problems since this problem began?: If yes, describe:
_____

Have you seen any other doctors for this problem? ___No ___Yes If yes, who? _____

How long ago? _____Days _____Weeks _____Months _____Years

What were the results of past treatment? _____

How is this problem NOW?: Circle One
Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

Please list any medication taken for this problem: _____

Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:
_____
_____
_____

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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)

<u>During Pregnancy</u> Explain: _____

◊ Drugs/medicine _____

◊ Tobacco/alcohol _____

◊ Illnesses _____

<u>During Labor and Delivery</u> Explain:_____

◊ Labor chemically induced _____

◊ Labor doctor assisted _____

◊ C-section delivery _____

◊ Forceps/vacuum extraction _____

◊ Doctor pull or twist baby _____

◊ Premature delivery _____

<u>Since Birth</u> Explain: _____

◊ Nursed how long:_____ _____

◊ Baby jaundiced _____

◊ Feeding problems _____

◊ Sleeping problems _____

◊ Colic _____

<u>Vaccinations</u> Explain: _____

◊ None _____

◊ Only selected vaccines _____

◊ Delayed schedule _____

◊ Regular schedule _____

◊ Any vaccine reactions _____

VRC# _____

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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 off skateboard/skates
Fall from changing table	Fall off monkey bars		

Allergies to_____

Other: _____

Insurance Information

Who is responsible for this bill? _____

Father's Insurance Mother's Insurance Other (please explain): _____

Policy #_____ Insurance Company Name_____

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

The risks associated with exposure to Radiation 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.

If Divorced

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 so 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

VRC# _____

(Staff Use only)

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 mean 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 2020

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(Staff Use only)

Parent 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:_____

Parent Signature: _____ Date: _____

Witness Signature:_____ Date:_____